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Accessibility of HIV Prevention, Treatment and Care Services for People who Use Drugs and Incarcerated People in Azerbaijan, Kazakhstan, Kyrgyzstan, Tajikistan, Turkmenistan and Uzbekistan

Legislative and Policy Analysis and Recommendations for Reform

UNODC
United Nations Office on Drugs and Crime

Title: Accessibility of HIV Prevention, Treatment and Care Services for People who Use Drugs and Incarcerated People in Azerbaijan, Kazakhstan, Kyrgyzstan, Tajikistan, Turkmenistan and Uzbekistan: Legislative and Policy Analysis and Recommendations for Reform

Abstract
This report analyses national programmes on HIV and drug control, administrative and criminal laws, and relevant governmental decrees and ministerial orders which were in effect in 2007-2009 in Azerbaijan, Kazakhstan, Kyrgyzstan, Tajikistan, Turkmenistan and Uzbekistan. Results of the analysis indicate that in the absence of regulatory frameworks that clearly enable and support evidence-based HIV prevention and treatment interventions, including harm reduction services, national laws, policies and programmes may and do hinder the full implementation of effective approaches to preventing and treating HIV infection among vulnerable groups such as prisoners and people who use drugs. These laws, policies and programmes embody: predominantly punitive drug control practices; limitations of the rights of people living with HIV, people who use drugs, and prisoners with HIV and/or drug dependence; broad provisions for non-voluntary medical interventions such as coercive drug testing, compulsory treatment of drug dependence, and mandatory HIV testing; and limited meaningful participation of civil society, including groups of people living with HIV, people who use drugs and prisoners, in the development, implementation and evaluation of the effectiveness of national strategies and laws both on HIV and on drugs.
This report presents recommendations to governments for legislative and policy reform aimed at strengthening the national response to the HIV epidemic and, specifically, at improving accessibility of evidence-based HIV-related services for drug users and incarcerated people. In addition, recommendations are also directed to UN and other international aid organizations for supporting countries in implementing such reforms.

Key words: 1. Human rights 2. HIV 3. Drug use 4. Prisons 5.Legislative review 6. Law reform 7. Central Asia 8. Azerbaijan

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ABBREVIATIONS AND ACRONYMS

AIDS	Acquired immunodeficiency syndrome
CESCR	Committee on Economic, Social and Cultural Rights
CHR	Commission on Human Rights
CIS	Commonwealth of Independent States
CND	Commission on Narcotic Drugs
EU	European Union
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
HIV	Human immunodeficiency virus
HRW	Human Rights Watch
ICCPR	International Covenant on Civil and Political Rights
ICESCR	International Covenant on Economic, Social and Cultural Rights
IDU	injection drug use (or injecting drug user)
IHRA	International Harm Reduction Association
IHRD	International Harm Reduction Development Programme
ILO	International Labour Organization
IPU	Inter-Parliamentary Union
OHCHR	Office of the (UN) High Commissioner for Human Rights
OSI	Open Society Institute
PLHIV	People living with HIV
TB	Tuberculosis
UDHR	Universal Declaration of Human Rights
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDCP	United Nations Drug Control Programme
UNDP	United Nations Development Programme
UNGASS	UN General Assembly Special Session
UNODC	United Nations Office on Drugs and Crime
WHO	World Health Organization

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EXECUTIVE SUMMARY

PROJECT BACKGROUND

In recent years, the region of Eurasia has seen one of the world's fastest-growing HIV epidemics, with unsafe drug injecting practices being a major driver. During the past decade, the region comprising countries of the former Soviet Union has experienced the highest increase in prevalence of drug use worldwide,[1] and UN agencies have recently estimated that injecting drug use accounts for more than 80% of all HIV infections in Eastern Europe and Central Asia.[2]

While the six countries participating in this legislative review and assessment — Azerbaijan, Kazakhstan, Kyrgyzstan, Tajikistan, Turkmenistan and Uzbekistan — differ with regard to HIV prevalence and the extent of their responses to HIV, they have much in common. All of the countries face concentrated HIV epidemics driven predominantly by unsafe drug-injecting practices and there is significant potential for the further rapid spread of HIV in Central Asia and Azerbaijan. Between 2000 and 2007, the number of officially recorded HIV cases in the region of Central Asia increased 15-fold.[3] Furthermore, according to local and international experts, official statistics may underestimate the real prevalence by a factor of ten.[4]

In countries that participated in the project, the spread of HIV is exacerbated by the high prevalence of other sexually transmitted infections (STIs). In addition to the fast-growing HIV epidemic, there is a severe tuberculosis (TB) problem in the region, a major contributor to deaths among people with immune system compromised by HIV; TB prevalence is particularly high among injecting drug users and prisoners.[5] HIV in prisons is another specific area of major concern, and is linked heavily to injection drug use inside and outside prisons. While people who inject drugs and people in prison are heavily affected by HIV, they are poorly covered by HIV prevention and treatment services.

According to UN agencies, "[i]n most countries of Eastern Europe and Central Asia, where injecting drug use accounts for more than 80% of all HIV infections, needle and syringe programmes regularly reach only 10% of the estimated number of injecting drug users."[6] Despite the acknowledged effectiveness of interventions such as needle and syringe programmes and opioid substitution therapy, data suggest that the overall coverage by such services of people who inject drugs remains limited,[7] and hundreds of thousands of people who use drugs do not have access to them because of legal and social barriers.

Legislative assessment and the need for human-rights based legislative and policy reform

In 2007-2008, under the auspices of the Regional Office for Central Asia of the United Nations Office on Drugs and Crime (UNODC), as part of the project *Effective HIV/AIDS prevention and care for vulnerable populations in Central Asia and Azerbaijan (2006-2010)*, an assessment of national legislation in Azerbaijan and five Central Asian countries (Kazakhstan, Kyrgyzstan, Tajikistan, Turkmenistan and Uzbekistan) was conducted in order to strengthen national capacity to achieve universal access to services for HIV prevention and treatment, with a special focus on people who inject drugs and people in prison. The project was carried out by teams of experts from all six participating countries, with the UNODC Regional Coordinator and national staff and the Canadian HIV/AIDS Legal Network ("Legal Network") serving as expert resources.

The assessment showed that there are many common issues of concern in the legislation and policies of the project countries. HIV prevention is not integrated into state health care systems (including health care services in prisons), meaning that health care professionals are often unfamiliar with effective, scientific methods of HIV prevention and treatment of HIV-infection and other concomitant health disorders for people at risk. Services for vulnerable populations are fragmented, uncoordinated, and governed by vague rules and referral schemes. There are few or no official standards for providing harm reduction services. In addition, outdated national laws often impede evidence-based approaches to HIV prevention among vulnerable groups, in particular harm reduction measures, and complicate relationships between low-threshold HIV-related services and law enforcement bodies. Hundreds of thousands of people who use drugs and people in prison have limited or no access to prevention and health care services because of structural, legal and social barriers. If done correctly, with the objective of facilitating greater access to good-quality services, clear legislation and regulation could assist in scaling up evidence-based measures for HIV prevention and treatment.

As almost everywhere in the world, in the Central Asian countries and Azerbaijan people who use illegal drugs and people in prisons are often among the most marginalised and stigmatized groups of society. Given administrative and criminal penalties for drug use and possession of small amounts of drugs for personal use, people who use drugs are at high risk of ending up in prison. They are vulnerable to abusive law enforcement practices, high rates of incarceration, and the denial of health services (both outside and inside prisons).[8] Inside prisons, people are often at higher risk of HIV infection, because of sharing drug-injection and tattooing equipment, as well as practicing unprotected sex, both consensual and non-consensual. Even countries that have invested heavily in drug interdiction efforts have not succeeded in stopping drug use in prisons.

It is widely recognized that responses to HIV and AIDS are much more efficient if human rights, particularly of those most vulnerable to HIV infection are protected: ensuring that law and policy are based on, and reflect, human rights norms and principles is essential, even though additional actions beyond just adopting sound law and policy are, obviously, also necessary to ensure the full enjoyment of human rights. A "rights-based approach" needs to be at the core of legislative review and reform, and such an approach will be of greatest benefit to public health.

International human rights treaties impose obligations on states to respect, protect, and fulfil a range of human rights, including in their national laws and policies. In the case of Azerbaijan and the Central Asian countries, these obligations include the obligation to take positive measures to realize, over time, the right to the highest attainable standard of health for all[9] — this includes people who use drugs and incarcerated people. The project countries have also committed to respecting and protecting numerous civil and political rights of great relevance to an effective response to HIV, including the rights to life, security of the person and privacy, to freedom of expression and association, as well the right to receive information.[10] Furthermore, underlying the entire body of international human rights law is the fundamental principle of non-discrimination, of particular relevance to people living with HIV and to those groups and individuals such as people who use drugs and people in prison, whose marginalization and exclusion, including through legally-sanctioned discrimination contributes to their vulnerability to HIV and to hindering their access to health and other services.

1 *Central Asia: Kyrgyz Republic, Tajikistan and Uzbekistan – Regional Study on Drug Use and HIV/AIDS, Regional Summary* (UNODC and World Bank, 2007), p. 16.

2 WHO, UNAIDS & UNICEF, *Towards Universal Access: Scaling up priority HIV/AIDS interventions in the health sector: Progress Peport 2008* (Geneva: WHO, 2008), p. 66.

3 UNODC (Regional Office for Central Asia), *Compendium of Drug-related Statistics 1997-2008* (June 2008), p. 32.

4 Ibid.

5 *Towards Universal Access* (2008), pp. 36-38.

6 *Towards Universal Access* (2008), p. 63.

7 *Towards Universal Access* (2008), p. 66-67, 69-70.

8 See more in D. Barrett et al., *Recalibrating the Regime: The Need for a Human Rights-Based Approach to International Drug Policy* (London: The Beckley Foundation Drug Policy Programme, 2008).

9 *International Covenant on Economic, Social and Cultural Rights*, UN General Assembly, 993 UNTS 3 (1966) (entered into force 3 January 1976), Article 12; UN Committee on Economic, Social and Cultural Rights, *General Comment 14: The right of everyone to the enjoyment of the highest attainable standard of physical and mental health*, UN Doc. XXX (2000).

10 *International Covenant on Civil and Political Rights*, UN General Assembly, 999 UNTS 171 (1966) (entered into force 3 January 1976), Articles 6, 17, 19, and 22.

OUTLINE OF REPORT

This publication consists of several components, as follows:

- Part I consists of an integrated report synthesizing key findings, concerns and recommendations emerging from the national legislative reviews and analyses in the six countries that participated in the project.

- Part II contains a detailed report for each of the six countries. Each report provides a description of the currently available evidence and the country's existing laws and policies of greatest relevance to HIV among people who use drugs and incarcerated people, and presents detailed recommendations for legislative and policy reform aimed at strengthening the country's response to HIV among these vulnerable populations.

- Part III contains a series of appendices which provide additional information about the project, and tools that can be used by legislators, policy-makers and others in implementing these recommendations.

PART I - INTEGRATED REPORT

The integrated report consists of six sections. The **first section** provides an overview of the project and its methodology. The **second section** provides general background information about the project countries, including a summary overview of the situation with HIV and AIDS and with drug use among the population as a whole and in prisons specifically.

The remaining four sections delve into specific areas of concern. Each of these sections is divided into the following sub-sections: (a) an overview of the situation; (b) the rationale for reform; and (c) recommendations for reform.

Section three presents information on *administrative and criminal law* issues related to drug use and non-violent drug-related offences. The assessment showed that in each of the six project countries, the law and its implementation reflect a punitive approach towards people who use drugs, and the national response to drugs accords a predominant role to law enforcement agencies, rather than health agencies. This approach often ignores evidence-based methods of HIV prevention and treatment and international standards of drug dependence treatment, and often contradicts public health interests.

Each country maintains administrative and criminal law prohibitions on drugs, and defines minimum and maximum amounts of narcotic drugs and psychotropic substances, the possession of which leads to administrative or (more often) criminal punishment. The project countries vary in how they define various small or large quantities of drugs, and the penalties associated with the different amounts, with Uzbekistan and Kazakhstan having stricter limits and harsher penalties and Tajikistan taking a somewhat more liberal approach.[11]

In most of the project countries, the national legislation makes a distinction between people who use drugs and people who deal drugs, by adopting the concepts of possession "for sale" and "not for sale". Azerbaijan is the only country whose law explicitly reflects the notion of possession "for personal use".[12] Drug use *per se* is formally prohibited in a number of the project countries, although it is not always penalized (e.g. with a specific penalty under the country's administrative or criminal code).[13]

11 For example, any quantity of heroin in Uzbekistan is classified as "large", while Kazakhstan's approach is effectively the same, defining any amount of heroin greater than 0.01 gram as "large".

12 In other countries, the law on drugs does not reflect the concept of possession for "personal use" or permissible possession of a quantity that is based on an "average single dose".

13 Legislation in Azerbaijan provides for administrative liability for drug use. In Tajikistan and Turkmenistan, drug use without a doctor's prescription is prohibited according to the laws on drugs, but there is no penalty defined in administrative or criminal codes. In Kazakhstan and Kyrgyzstan, drug use in public places leads to administrative penalty; possession of insignificant quantities of a narcotic substance in Kazakhstan may entail criminal charges. Uzbekistan does not have either administrative or criminal liability for drug use, nor does the law on drugs state any prohibition of it.

In general terms, the objective of recommendations for reforming administrative and criminal law in the project countries is the humanization of policies related to drug use and to non-violent drug related offences by:

- repealing administrative liability for mere drug use and administrative and criminal liability for possession of small amounts of drugs not for the purpose of sale;
- ensuring that harm reduction programmes are not prosecuted for "incitement of drug use", drug "propaganda", operating a "site for drug consumption" or similar offences;
- widening the spectrum of alternatives to imprisonment for those convicted of non-violent drug-related criminal offences and limiting the use of pre-trial detention; and
- prohibiting random compulsory referral for drug testing by law enforcement authorities.

In addition, the legislative analysis identified other areas of criminal and administrative law that may hinder an effective response to HIV among other vulnerable groups in addition to people who use drugs or are in prison — namely, the criminalization of marginalized groups such as sex workers and, in two countries, men who have sex with men, as well as the specific targeting of HIV transmission and exposure for criminal prosecution. These approaches run contrary to international human rights standards and/or international policy recommendations. This section of the Integrated Report presents a detailed rationale for these reforms and general recommendations on these issues, with more detailed, country-specific recommendations in the individual country reports (Part II).

Section four presents information about *legislation related to health care systems and services*. In each of the project countries, health care is guaranteed by the state. As stated in the law, it is provided free-of-charge according to place of permanent residence based on a certificate of domicile. However, in all six countries that participated in the project, people who use drugs have limited access to health care and HIV prevention. Harm reduction services are rare, marginalised, and not integrated into legislation and governmental policies.

Typically, drug dependence treatment in all six countries is aimed at full abstinence, and consists largely of detoxification and some non-standardized psychosocial interventions; access to other treatment methods and options recommended by international organizations is limited at best or simply non-existent. The effectiveness of this system is low, according to clients interviewed by national expert groups in some of the project countries[14] and, according to data provided by the national expert groups, it is not well evaluated officially. Although opioid substitution treatment (OST) is becoming increasingly available globally, in two countries that participated in the analysis (Tajikistan and Turkmenistan) it is still not available, the single pilot OST project was cancelled in Uzbekistan in 2009, and in the other three countries (Azerbaijan, Kazakhstan and Kyrgyzstan) the coverage remains low.[15]

Compulsory drug dependence treatment in one form or another exists in all six countries that participated in the study — both in the community and in prison. The law generally allows for compulsory treatment of people with alcoholism and drug dependence who refuse to undergo "voluntary" treatment and whose behaviour disturbs public order or threatens the well-being of others. In all of the project countries, narcological facilities under the purview of the Ministry of Health provide compulsory treatment for non-offending drug-dependent people. Turkmenistan also maintains a so-called treatment-labour camp *(лечебно-трудовой профилакторий)* run by the Ministry of Interior. The level of compulsory treatment of drug dependence for non-offenders varies in the project countries: in Tajikistan, Azerbaijan and Kyrgyzstan, there is in practice little or no enforcement of such compulsory treatment, whereas in Kazakhstan, Turkmenistan and Uzbekistan, each year an estimated 6-13% of all persons undergoing drug dependence treatment are doing so under compulsion, according to UNODC (UNODC, 2009, unpublished data). Compulsory drug dependence treatment for prisoners is used in all countries participating in the project.[16]

In all of the project countries, it is standard practice to *register* the names and other information about people who use controlled substances and people with drug dependence at narcological facilities. The

14 Intervews conducted by the expert groups of Kazakhstan and Uzbekistan; see also: Human Rights Watch, *Fanning the Flames: How Human Rights Abuses are Fuelling the AIDS Epidemic in Kazakhstan* (2003).

15 See summary country reports.

16 Provisions for compulsory drug treatment are established by specific laws on compulsory treatment (e.g., in the case of Tajikistan, Turkmenistan and Uzbekistan), by special sections in the countries' *Criminal Codes* governing drug dependence treatment in prisons; and national laws on drugs.

existing legal provisions that regulate registration of people who use drugs at medical facilities allow for numerous negative consequences of registration, including exposing registered persons to legally-sanctioned discrimination in such areas as employment and/or education.

Many of the national HIV policies in the project countries are outdated, with wide provisions for mandatory or compulsory HIV testing. Although national HIV laws may only explicitly mention mandatory or compulsory testing for HIV in some limited circumstances (e.g., blood donors, foreign nationals), they generally fail to prohibit explicitly the broader application of involuntary testing. It is often ministerial or departmental guidelines, orders or instructions that expand the categories of people who are subject to HIV testing that is not fully voluntary. There are also frequent breaches of confidentiality regarding HIV status of those tested.

This section first puts forward some recommendations aimed at eliminating systemic barriers to access to health care services. It also identifies ways in which the project countries should update existing or adopt new national laws and strategies in the areas of HIV and of drugs, so as to ensure that:

- the country's responses to the interconnected health problems of HIV and of drugs address the particular vulnerability of people who use drugs and people in prisons, including through guaranteeing easy access to effective services for preventing and treating drug dependence and reducing the harms associated with drug use;
- civil society and vulnerable groups are involved in the development, implementation and evaluation of these national policies and programmes on HIV and on drugs; and
- health workers and law enforcement personnel have an informed understanding of HIV, drug dependence and harm reduction, as well of human rights, so that their work would contribute to an effective response.

In addition, this section puts forward some detailed recommendations regarding the legislative basis for (1) drug dependence treatment, and (2) HIV prevention and treatment, with a particular focus on people who use drugs. It is recommended to amend national legislation, policies, regulations, guidelines and protocols to guarantee:

- the universal availability and accessibility of a variety of voluntary treatment options for drug dependence, including easy access to opioid substitution treatment (OST);
- the application of compulsory drug dependence treatment only as a measure of last resort and, if applied, in full compliance with human rights principles and WHO recommended clinical protocols;
- full confidentiality of patients' identity and health information, and the prohibition of using information from medical records of people who use and/or are dependent on drugs (i.e., from narcological registries) for reporting, without the explicit and documented informed consent of the patient.

Recommendations regarding HIV prevention and treatment include the development of legal, regulatory and policy provisions that will:

- ensure universal access to HIV testing, accompanied by quality pre- and post-test counselling, that is fully voluntary, informed and strictly confidential (and mandate access to truly anonymous HIV testing in at least some settings);
- explicitly prohibit mandatory and compulsory HIV testing (with the exception of mandating testing of donors of blood, organs, tissue or other bodily substances);
- guarantee full confidentiality of medical information, including HIV test results, and ensure that there are effective, accessible means of legal redress for persons whose right to confidentiality of medical information is violated;
- guarantee easy access to HIV-related care, including antiretroviral treatment (ARV) and especially for people who use drugs and people in prison who are HIV-positive; and
- guarantee easy access to TB services for drug dependent people and people living with HIV, including by integrating TB and HIV-related health care.

Section five examines *access to health services in prisons*, particularly HIV prevention and treatment.

There were an estimated 135,000 people in prison in the project countries in 2008; a significant percentage of them were serving a sentence for drug-related offences.[17]

In some of the project countries, drug use in prison is recognized by the authorities (e.g., Kyrgyzstan, Kazakhstan, Tajikistan), but there remain very few prison-based programmes to protect people who inject drugs from infectious diseases and other harms. Bleach is provided in most of the project countries, but it appears that prisoners are not given information about the most effective use of bleach to clean equipment used for drug injection (or tattooing), and are not allowed to seek and use bleach confidentially. UN agencies and other health experts widely recognize that provision of bleach is a sub-standard measure and not a substitute for access to sterile injection or tattooing equipment. With respect to harm reduction services other than provision of bleach, Kyrgyzstan's policies are the most advanced of the six project countries: both OST and needle and syringe programmes exist in the country's prisons. At this writing, these programmes are not available in prisons in the other project countries.

According to some country reports, prisoners often have to pay for medication and personal hygiene products, and access to specialised health care (STI treatment, dental care, etc.) is limited or unavailable.

In all the project countries, people in prison are subject to compulsory drug dependence treatment. Courts commonly order compulsory treatment as part of sentencing, in addition to other criminal penalties — even though international drug control treaties explicitly allow for *alternatives* to conviction and incarceration for drug offences, including providing treatment and rehabilitation services as alternatives, instead of imposing these *in addition to* criminal penalties.[18] According to national laws, voluntary drug dependence treatment in prisons is provided in almost all project countries (with the exception of Turkmenistan). However, the national experts note that in reality very few people in prison who need drug dependence treatment undergo it voluntarily.

In all of the project countries, the law allows for compassionate release from prison of people with terminal illness; generally, this is thought to be available to at least some patients diagnosed with AIDS, although usually AIDS is not specifically mentioned. There are specific, discriminatory restrictions on the rights of prisoners with HIV and/or prisoners who have not completed compulsory drug dependence treatment, such as denying eligibility for transfer to prisons with less strict security regimes.
In general terms, the recommendations in this section aim at strengthening the response to HIV in prisons by developing norms and regulations that will:

- include HIV prevention and treatment in prisons in national strategies and programmes and specify clear funding sources for these measures;
- ensure the availability and accessibility of adequate health care services in prisons;
- make national health authorities responsible for prison health (as opposed to the Ministry of Justice or the Ministry of Interior), in order to make it easier to guarantee that people in prison are entitled to the same efforts to protect and promote health, and to the same health services, as people outside prisons;
- regulate the provision of information about HIV and AIDS and training for both prison staff and prisoners;
- ensure easy, confidential access to disinfectants such as bleach and to sterile injection and tattooing equipment;
- introduce easy access to voluntary drug dependence treatment (including OST) in prisons and limit the use of compulsory drug dependence treatment in prison settings;
- ensure access to antiretroviral treatment (ARV) in prison;
- ensure access to voluntary and confidential HIV testing, with counselling and informed consent, in prisons; and
- enable NGO contributions to HIV prevention and care in prisons, as well as supporting people in prisons to do peer HIV education and outreach to other prisoners.

17 An estimated one-third of those in Tajikistan in prison had previously injected drugs and according to the national expert group, one-third were serving sentences for drug-related offences at the time of their review in 2007. 21.4% of people in prison were serving drug-related sentences in Uzbekistan.

18 *Single Convention on Narcotic Drugs*, 1961, UN, 520 UNTS 331, as amended by the 1972 Protocol, Article 36(2); *Convention on Psychotropic Substances*, 1971, UN, 1019 UNTS 175, Article 22; *Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances*, 1988, Article 3(4).

Section six provides information and recommendations regarding *legislative discrimination and other restrictions of rights* of people living with HIV or vulnerable to HIV**.** All six of the project countries have general anti-discrimination provisions in their Constitutions and other legislation. However, there are no specific statutes to prohibit discrimination; rather, discriminatory acts towards certain groups may be prohibited in laws concerning these groups. Employment laws may also contain non-discrimination clauses, while health laws may contain non-discrimination clauses and/or the obligation on health care professionals to render medical care to everyone. In some project countries, the violation of such non-discrimination (or equality) clauses is penalized by that country's *Criminal Code*. Similarly, in some of the countries, legislation establishes the possibility of criminal liability for a discriminatory refusal to provide medical services.

Nevertheless, contradicting such prohibitions, discrimination is often formally permitted by the law in areas such as employment and education, family life and some other areas. A number of the countries formally prohibit people who are living with HIV and people who use drugs from working in certain occupations or positions. In case of HIV infection, such prohibitions are often accompanied by — and made operational through — mandatory HIV testing for people working in, or applying to work in, certain positions. In some project countries, people seeking to enrol in vocational training and higher education institutions are required to present a medical certificate, which includes a number of points (such as not being on the registry as a person who uses drugs or is dependent on drugs or alcohol, and may in certain cases include HIV status). In countries where HIV testing is required in order to enrol in some types of educational institutions, such as a military academy, this provision infringes the right to education.

Many of the project countries deport non-citizens living with HIV. This practice is sometimes associated with — and made operational through — mandatory HIV testing of foreigners and stateless persons. There are also restrictions on the right to found a family, such as when a government resolution lists the diseases that automatically prevent someone from adopting children (the list includes both HIV and drug dependence).

Recommendations to address such discrimination embedded in the law include the development or elaboration of provisions that would:

- strengthen existing legislative protections against HIV-based discrimination where there are gaps;
- introduce legal protection against discrimination based on drug dependence;
- recognize both HIV infection and drug dependence as disabilities for at least some legal purposes (e.g., protection against discrimination based on disability); and
- eliminate unjustified restriction or denial of rights of people who use drugs and people living with HIV such as unjustified discrimination in employment and educational institutions, immigration policies and in family relations.

PART II - COUNTRY REPORTS

Part II of this publication consists of six individual country reports, arranged following the same general structure as the Integrated Report — a general overview of the country's legal system; its administrative and criminal laws related to drugs; access to health care services, including drug dependence prevention and treatment and HIV prevention and treatment (with a focus on people who use drugs); specific issues related to HIV prevention and treatment in prisons; and anti-discrimination provisions. Each individual country report concludes with a detailed set of recommendations tailored specifically to the country's context, including current legislation and policy. These individual country reports, while lengthy and detailed, are distilled from the more detailed legislative assessment conducted by each of the six national expert groups and additional material gathered by those groups, the project's technical advisors and UNODC staff.

PART III – APPENDICES

Part III contains a number of appendices, which include the assessment tool used by the national expert groups, the teaching module delivered to guide these groups in their assessments, and tables with some country data that will be of interest to national policy-makers, researchers and various specialists, as well as a glossary of terms used in the report.

Key findings and conclusions

In summary, the assessment of national laws and policies in relation to people who use drugs and prisoners showed that there are issues common to all six countries in achieving universal access to HIV prevention and treatment. All countries have national laws that hinder the implementation of evidence-based approaches to preventing and treating HIV among vulnerable groups such as prisoners and people who use drugs. Current attitudes and policies sometime contribute to complicating interaction between HIV prevention services and law enforcement agencies. In general, the main issues that have been identified by the countries' expert teams and the international experts can be considered to fall into the following broad categories:

- punitive drug policies towards people who use drugs including their incarceration (sometimes for possession of very small amounts of drugs) and few or no alternatives to incarceration for people who use drugs in the case of non-violent offences;

- limitations of the rights of people living with HIV, people who use drugs, and prisoners with HIV and/or drug dependence, and no effectively enforceable anti-discrimination provisions;

- broad provisions for non-voluntary medical interventions such as coercive drug testing, compulsory treatment of drug dependence, and mandatory HIV testing;

- absence of regulatory frameworks that clearly enable and support evidence-based HIV prevention interventions, including harm reduction services, that results in low access of people who use drugs and incarcerated persons to effective HIV prevention and treatment interventions;

- insufficient availability of effective drug dependence treatment services, especially of opioid substitution treatment (i.e. no OST in some countries or low capacity pilot programmes in a few others), and limited or no rehabilitation and overdose prevention programmes in communities and in prisons; and

- limited meaningful participation of civil society, including groups of people living with HIV, people who use drugs and prisoners in the development, implementation and evaluation of the effectiveness of national strategies and laws on both HIV and on drugs.

This report should assist national policy-makers and legislators to revisit laws and policies governing the accessibility of health care in general and of HIV-related services in particular — including those regulating drug dependence treatment and access to health care in custodial settings — and to develop them in line with best, evidence-based practices and human rights principles. Amendments should be developed for health care laws (confidentiality, informed consent to medical procedures and treatment, limiting the use of coercive medical measures), HIV laws (HIV testing, repeal of discriminatory practices), social protection and family legislation (disability, child custody and adoption, deprivation of parental rights), and administrative and criminal laws (provisions on drug use/possession for personal use, alternatives to imprisonment, compulsory treatment of drug dependence). The recommendations should also be reflected in national programmes on HIV, tuberculosis, drug control, and criminal justice/penal reform. To make these recommendations operational it will be necessary to align regulations and implementing practices with the amended laws. This will allow for the introduction and improvement of protocols and standards of services, improvements in reporting and accountability of services, and improved professional education and vocational training. These reforms will contribute to the protection of people living with HIV, people who use drugs and prisoners from violations of their rights, including discrimination and punishment on the ground of their health status, while providing for universal access to evidence-based health interventions. The reforms will make national legislation and norms compliant with states' obligations to respect, protect and fulfil the human rights of these populations, including their right to health — and, therefore, ultimately will benefit the public health and society's well-being as a whole.

I. INTEGRATED REPORT

1. INTRODUCTION

1.1 BACKGROUND TO THE PROJECT

This report covers six countries of the former Soviet Union: Azerbaijan and the five Central Asian countries of Kazakhstan, Kyrgyzstan, Tajikistan, Turkmenistan and Uzbekistan who have participated in the UNODC-supported project "Effective HIV prevention and care among vulnerable populations in Central Asia and Azerbaijan" (2006-2010).

While the project countries differ with regard to HIV prevalence and the extent of their responses to HIV, they have much in common. According to the United Nations, in recent years the region has experienced one of the world's fastest growing HIV epidemics, resulting mainly from unsafe drug-injecting practices.[19] While people who inject drugs account for approximately 10% of HIV infections globally, in Central Asia and Eastern Europe injecting drug use accounts for more than 80% of all HIV infections.[20] All of the countries face concentrated HIV epidemics, with the prevalence of HIV infection among injecting drug users reaching 33 per cent in some urban sites.[21]

There is also significant potential for the further rapid spread of HIV in Central Asia and Azerbaijan. Between 2000 and 2007, the number of officially recorded HIV cases in the region of Central Asia increased 15-fold.[22] As of 2008, roughly 2 million people were living with HIV in the countries of the former Soviet Union, indicating a 20-fold increase in HIV incidence in less than a decade.[23] Between 2000 and 2003, the annual number of new HIV infections tripled in Kyrgyzstan and Azerbaijan, and grew nine-fold in Kyrgyzstan, 16-fold in Uzbekistan and 17-fold in Tajikistan.[24] Furthermore, according to local and international experts, official statistics may underestimate the real prevalence by a factor of 10.[25] In addition to the fast-growing HIV epidemic, there is a serious tuberculosis (TB) problem in the region, a major contributor to deaths among people with immune systems compromised by HIV; TB prevalence is particularly high among injecting drug users and prisoners. According to UN data, in 2008 multidrug-resistant TB had reached the highest rates ever encountered. Azerbaijan and Uzbekistan were among the countries reporting the highest prevalence rates.[26]

HIV in prisons is another specific area of major concern, and is intimately linked to injection drug use. For example, in Tajikistan there are reports of HIV transmission in prisons: according to official data, HIV prevalence among prisoners in two surveillance cities (Dushanbe and Khujand) increased from 6.2% in 2005 to 8.4% in 2006.[27] In Uzbekistan, the highest prevalence rates of HIV are found among prisoners.[28] In Kyrgyzstan, the reported cumulative number of HIV cases in prisons in 2007 was almost 120 times the national average. It is reported that 60% of prisoners use drugs while incarcerated, with the majority injecting.[29]
While people who inject drugs and prisoners are heavily affected by HIV, they are poorly covered by HIV prevention and treatment services. Globally, an estimated 15.9 million (range 11.0 – 21.2 million) people inject drugs, and an estimated 3.0 million (range 0.8 – 6.6 million) of them are living with HIV.[30] Despite the acknowledged effectiveness of interventions such as needle and syringe programmes (NSPs) and opioid substitution therapy (OST), data suggest that the overall coverage by such services of people who inject drugs remains limited,[31] and hundreds of thousands of people who use drugs do not have access to them because of legal and social barriers.

According to UN agencies, "[i]n most countries of Eastern Europe and Central Asia, where injecting drug use accounts for more than 80% of all HIV infections, needle and syringe programmes regularly reach only 10% of the estimated number of injecting drug users."[32] In 2007, the best results in the region were reported from Tajikistan and Uzbekistan, which managed to exceed the threshold of at least one needle and syringe programme site per 1000 drug injectors, comparable to coverage achieved by all high-income countries in Europe.[33]
Although countries are increasingly scaling-up access to opioid substitution treatment, as of December 2009, it was still not available at all in two countries that participated in the project (Tajikistan and Turkmenistan), and consisted of only two pilot programmes introduced in 2008 in another (Kazakhstan). In Azerbaijan and Kyrgyzstan, coverage remains low, and in Uzbekistan, in June 2009 the government discontinued its pilot OST project.[34] As for access to antiretroviral (ARV) therapy, in 2006 in Eastern Europe and Central Asia, approximately 79% of reported HIV cases were among people who injected drugs, but they represented only 39% of people receiving ARV therapy.[35]

The countries participating in this project generally have a variety of statutory provisions and other legal instruments on HIV as well as national plans and strategies on both HIV and drug use. Often, these remain but provisions on paper, without adequate resources for their implementation, and do not provide real protection to vulnerable and at-risk populations. Furthermore, partly because of the absence of clear legal regulations on HIV-related preventive interventions for most at risk groups (such as people who inject drugs), often HIV prevention and treatment services (including in prisons) are not well integrated into the broader state health care system, as theoretically only AIDS centres are responsible for HIV prevention and treatment. As a result, most health professionals are unfamiliar with evidence-based effective methods of HIV prevention and treatment for people at risk, and services meant for vulnerable populations are fragmented, uncoordinated and governed by vague rules and referral schemes. There are few official standards for providing harm reduction interventions. Outdated or inadequate national legislation impedes scaling up evidence-based approaches to HIV prevention among vulnerable groups, in particular harm reduction measures, and complicates relationships between staff of HIV-related services and law enforcement personnel.

Finally, in most of the project countries, the national legislative and policy approach is to treat drugs, and the people who use them, predominantly as objects of criminal and other coercive measures, rather than recognizing drug use primarily as a health matter and framing the response accordingly as an individual and public health concern. As a result, the formulation and implementation of legislation and other legal instruments often does not take into account the consequences and influence on the lives and status of vulnerable and marginalised groups or on public health more broadly.

This report focuses on people who inject drugs and people in prison, two populations particularly vulnerable to HIV, and presents results of a comprehensive assessment and analysis of relevant national legislation in the six project countries. The document gives a set of recommendations for the legislative and policy reforms necessary to remove barriers and enhance access of these marginalised groups to HIV prevention, care, treatment and support to help countries to fulfil their commitments to achieve universal access to HIV related services for their populations.

19 *Central Asia: Kyrgyz Republic, Tajikistan and Uzbekistan – Regional Study on Drug Use and HIV/AIDS, Regional Summary* (UNODC and World Bank, 2007), p. 16 [hereinafter "Central Asia Regional Study on Drug Use and HIV/AIDS"].

20 WHO, UNAIDS & UNICEF, *Towards Universal Access: Scaling up priority HIV/AIDS interventions in the health sector: Progress Peport 2008* (Geneva: WHO, 2008), p. 66.

21 N. Kerimi, "Accessibility of opioid substitution treatment in countries of Central Asia and in Azerbaijan: recent developments and next steps," Presentation at the 4th Central Asian Partnership Forum on HIV infection (Almaty, Kazakhstan, 9-10 November 2009).

22 UNODC (Regional Office for Central Asia), *Compendium of Drug-related Statistics 1997-2008* (June 2008), p. 32.

23 UNAIDS & WHO-Europe, *Policy Brief: Progress on implementing the Dublin Declaration on Partnership to Fight HIV/AIDS in Europe and Central Asia* (2008), p. 5.

24 UNDP, Central Asia Human Development Report — "Bringing down barriers: Regional cooperation for human development and human security," Central Asia Human Development Report (2005), p. 146 [hereinafter "Central Asia Human Development Report 2005"].

25 Ibid.

26 *Towards Universal Access* (2008), pp. 36-38.

27 National progress report on the Declaration of Commitment on HIV/AIDS to the Special Session of the UN General Assembly: Tajikistan 2007 [Национальный доклад о ходе выполнения декларации о приверженности делу борьбы с ВИЧ/СПИД Специальной Сессии Генеральной Ассамблеи ООН] (presented 31 January 2008).

28 See summary report for Uzbekistan below in Part II.

29 *Central Asia Regional Study on Drug Use and HIV/AIDS*, p. 36.

30 B.M. Mathers et al., "Global epidemiology of injecting drug use and HIV among people who inject drugs: a systematic review," *Lancet* 2008; 372: 1733-1745.

31 *Towards Universal Access* (2008), p. 66-67, 69-70; B.M. Mathers et al., "HIV prevention, treatment, and care services for people who inject drugs: a systematic review of global, regional, and national coverage," *Lancet* 2010; 375: 1014-1028.

32 Ibid. "Regular reach" is defined as contact at least once per month: ibid., p. 63.

33 Ibid., p. 67.

34 For more details, see individual country reports in Part II.

35 WHO-Europe & UNAIDS, *Progress on implementing the Dublin Declaration on Partnership to Fight HIV/AIDS in Europe and Central Asia* (2008), pp. 79-80.

1.2 RATIONALE FOR LEGISLATIVE REFORM AND THE IMPORTANCE OF HUMAN RIGHTS-BASED POLICY

> "Reliance on criminal sanctions as the major response to illicit drug use inevitably results in the denial of human rights of the IDU [injecting drug user] population as drug use remains defined as a law enforcement rather than a health problem. Poor health outcomes in this population then follow, because health promotion and health care services are more difficult to provide to a now stigmatized and underground population. Protection of human rights is an essential precondition to improving the health of individual drug users and improving the public health of the communities where they live."
>
> A. Wodak, "Health, HIV Infection, Human Rights, and Injecting Drug Use," *Health and Human Rights* 1998; 2(4): 24–41.

In their 2000 *Millennium Declaration*, UN Member States resolved, among other commitments, to have halted and begun to reverse the spread of HIV by the year 2015.[36] In the 2001 *Declaration of Commitment on HIV/AIDS* adopted by the UN General Assembly, all countries recognized that the realization of human rights and fundamental freedoms for all is an essential element of a global response to the HIV pandemic, including in the areas of prevention, care, support and treatment, and that it reduces vulnerability to HIV and prevents stigma and related discrimination against people living with or at risk of HIV infection .[37] Five years later, in 2006, in their *Political Declaration on HIV/AIDS*, UN member states reaffirmed the earlier commitments to overcoming legal, regulatory or other barriers that block access to effective HIV prevention, treatment, care and support, including access to medicines and other commodities and to services.[38] UN Member States committed to striving to achieve the goal of "universal access" to HIV prevention, treatment, care and support by 2010.[39] It is now widely accepted that responses to HIV and AIDS are much more efficient if the human rights, particularly of those most vulnerable, are protected.

Such commitments are especially relevant to the effort to ensure universal access for vulnerable groups such as people who use drugs and prisoners, given the key role that laws and policies, and their implementation, play in affecting these groups' access to the means of HIV prevention and to adequate HIV care. Traditionally, policies on drug use have focussed on reducing both the supply of and demand for narcotic substances. Yet it has been documented repeatedly that supply and demand reduction policies that are primarily or wholly dependent on enforcing criminal prohibitions on drugs and drug use lead to a whole range of negative impacts on the health and the human rights of people who use drugs.[40] International human rights standards oblige States to respect, protect and fulfil the full range of human rights, including the right to the highest attainable standard of health, for all, which includes people who use and/or are dependent on drugs and people in prison. When human rights are disrespected, unprotected or unfulfiled — particularly for groups most at risk, such as injecting drug users and prisoners — this impedes efforts to prevent the spread of HIV and to ensure access to care, treatment and support for those with HIV, and this ultimately negatively affects public health generally.

As with other areas of law and policy, efforts to decrease supply and demand of drugs must be consistent with States' human rights obligations, and to be sound public policy, must also be balanced with effective and proven measures to protect the health of people who use drugs and the public as a whole, including harm reduction interventions.[41] There is, therefore, an urgent need in the countries of the region to review — and in many cases, reform — national legislation and policy, taking into account its influence on the status of people who use drugs and prisoners, on their access to information, tools and services for HIV prevention, care, treatment and support. Obviously, legislative and policy reform is not a panacea for preventing or treating HIV infection among people who use illegal drugs, prisoners or other at-risk populations. However, while it may not be sufficient on its own, it is a necessary but often neglected element of a comprehensive response to the epidemic.

36 *United Nations Millennium Declaration*, UN General Assembly Resolution 55/2, UN Doc. A/RES/55/2 (2000), para 19.

37 *Declaration of Commitment on HIV/AIDS,* UN General Assembly Reslution S-26/2, UN Doc. RES/S-26/2 (2001).

38 *Political Declaration on HIIV/AIDS*, UN General Assembly Resolution 60/262, UN Doc. A/RES/60/262 (2006), para. 20.

39 Ibid..

40 E.g., see *At What Cost?: HIV and Human Rights Consequences of the Global "War on Drugs"* (New York: Open Society Institute, 2009); D. Wolfe & K. Malinowska-Sempruch, *Illicit Drug Policies and the Global HIV Epidemic: Effects of UN and National Government Approaches* (New York: Open Society Institute, 2004).

41 D. Barrett et al., Recalibrating the Regime: The Need for a Human-Rights Based Approach to International Drug Policy, The Beckley Foundation Drug Policy Programme, Report Thirteen (2008), online via www.aidslaw.ca/drugpolicy.

Efforts to address HIV epidemic should be based on human rights and aimed at enhancing public heath

In their national legislation, countries are required to take into account their obligations under international law and respect, protect and fulfil human rights, such as the following obligations of particular relevance to the response to HIV and AIDS:

- According to the *Charter of the United Nations,* all countries that belong to the UN have a binding treaty obligation "to take joint and separate action" to achieve the purpose of the UN, including promoting "universal respect for, and observance of, human rights and fundamental freedoms for all."[42]

- The *Universal Declaration of Human Rights* declares that "everyone has the right to a standard of living adequate for health and well-being," including "medical care and necessary social services."[43]

- States that are parties to the *International Covenant on Economic, Social and Cultural Rights*, including all six of the project countries, have recognized the right of every person to enjoy "the highest attainable standard of physical and mental health."[44] These States have a binding legal obligation to take steps to realize fully this right, including those steps "necessary for … prevention, treatment and control of epidemic, endemic … and other diseases" and "the creation of conditions which would assure to all medical services and medical attention in the event of sickness."[45] The UN Committee on Economic, Social and Cultural Rights, the expert body charged with assessing states' compliance with their obligations under the ICESCR, has explained that "the right to health must be understood as a right to the enjoyment of a variety of facilities, goods, services and conditions necessary for the realization of the highest attainable standard of health."[46]

- In addition, the *International Covenant on Civil and Political Rights* (ICCPR) states that every person has the inherent right to life.[47] The Human Rights Committee, the expert body charged with addressing states' compliance with their obligations under the ICCPR, has explained that this right "should not be interpreted narrowly" and that governments must adopt positive, proactive measures to protect human life, including measures that can help reduce the spread of epidemics.[48]

Translating these and other human rights norms into practical actions in the context of HIV is the purpose of the *International Guidelines on HIV/AIDS and Human Rights*, originally produced by the Office of the UN High Commissioner for Human Rights (OHCHR) and UNAIDS in 1998 and updated in 2006. The Guidelines provide expert guidance to states on how to respond to HIV and AIDS through legislation, policies and practice that protect human rights and achieve public health goals. Of particular note, the *International Guidelines* recommend that harm reduction measures (e.g., clean injection equipment) be part of efforts to prevent HIV infection among injecting drug users and prisoners, and that the criminal law in particular should be reviewed to ensure that it is not an impediment to such measures.[49]

Countries participating in this project have themselves recognized the importance of addressing HIV among injecting drug users and in prisons, including with harm reduction measures. The *Dublin Declaration on Partnership to Fight HIV/AIDS in Europe and Central Asia*, signed by heads of states and governments in February 2004, reaffirmed the fundamental importance of human rights "to preventing transmission of HIV, reducing vulnerability to infection and dealing with the impact of HIV/AIDS."[50] Recognising

42 *Charter of the United Nations*, UNTS 993 (entered into force 24 October 1945), Articles 55, 56.

43 *Universal Declaration of Human Rights*, UN General Assembly, Resolution 217 A(III), UN GAOR, 3rd Sess., Supp. No. 13, UN Doc. A/910 (1948) 71, Article 25.

44 *International Covenant on Economic, Social and Cultural Rights*, UN General Assembly, 993 UNTS 3 (1966) (entered into force 3 January 1976), Article 12 [hereinafter ICESCR].

45 ICESCR, Article 12.

46 UN Committee on Economic, Social and Cultural Rights, *General Comment 14: The right to the highest attainable standard of health*, UN Doc. E/C/12/2000/4 (2000).

47 *International Covenant on Civil and Political Rights*, UN General Assembly, 999 UNTS 171 (1966) (entered into force 3 January 1976), Article 6 [hereinafter ICCPR].

48 UN Human Rights Committee, *General Comment 6: The right to life (Art.. 6),* UN Doc. HRI/GEN/1/Rev.1 (1982) at p. 6.

49 Office of the High Commissioner for Human Rights & UNAIDS, *International Guidelines on HIV/AIDS and Human Rights* (2006 Consolidated Version), para. 21(d)-(e).

50 *Dublin Declaration on Partnership to Fight HIV/AIDS in Europe and Central Asia*, signed 24 February 2004, online: http://www.euro.who.int/aids/treatment/20051018_1.

that in the region prisoners and people who inject drugs are among those at highest risk of HIV, the Declaration set out participating countries' commitment to promote, enable and strengthen the widespread introduction of HIV prevention, drug dependence treatment and harm reduction programmes — such as needle and syringe programmes, bleach and condom distribution, voluntary HIV counselling and testing, opioid substitution therapy, and STI diagnosis and treatment — in line with national policies.[51] Countries that adopted the Dublin Declaration pledged to scale up programmes so that by 2010 at least 80% of those at highest risk of and most vulnerable to HIV and AIDS are covered by a wide range of prevention programmes providing access to information, services and prevention tools.[52]

The Dublin Declaration stressed the need to identify and address factors that make these groups and communities particularly vulnerable to HIV and to promote and protect their health. In its position paper released the following year, *Intensifying HIV Prevention*, UNAIDS recommended not only specific services and tools that must be in place (see Box 1), but highlighted again the **necessity of legal analysis and the reform of legal frameworks** in order to remove legal barriers to effective and evidence-based interventions for HIV prevention, to overcome stigma and discrimination and to protect the rights of people living with HIV or at high risk of HIV infection.[53]

Box 1: UNAIDS' practical guidelines for intensifying HIV prevention among people who inject drugs and in prisons[54]

People who use drugs

In relation to people who use drugs, UNAIDS advises that the most effective and cost-effective HIV prevention programmes among people who use drugs are harm reduction measures, and that effective HIV prevention requires at least the following:

- Adequate coverage and low threshold access — including in correctional settings, to sterile injection equipment — to meet actual patterns of drug use.
- Access to quality, non-coercive drug treatment programmes especially drug substitution treatment such as methadone and buprenorphine.
- Removal of stigmatizing and coercive measures such as mandatory registration of PLHIV and forced HIV testing.
- Removal of legal barriers to access prevention and care, such as laws and policies that prevent the provision of sterile injecting equipment and/or access to drug substitution treatment such as methadone and buprenorphine and meaningful involvement of drug users at all levels of planning and policy and financial support for their organizations.

People in prison

In relation to people in prison, UNAIDS recommends, among other measures, the following:

- Removal of legal barriers and reform of prison procedures/rules to enable access to HIV prevention and care services by prisoners.
- Availability of condoms, sterile syringes and needles and skin-piercing equipment, and promotion of consistent and proper use of condoms.
- Access to drug treatment programmes, especially drug substitution treatment, with adequate protection of confidentiality.
- Access to HIV counselling and testing, antiretroviral and TB treatment and care and quality treatment of sexually transmitted infections.
- Review of drug control laws; provision of alternatives to imprisonment for minor drug-related offences; offer of treatment for drug users instead of imprisonment.

In 2009, the WHO, UNODC and UNAIDS issued a Technical Guide spelling out what is meant by comprehensive HIV prevention programmes for injecting drug users — namely nine essential interventions: (1) needle and syringe programmes; (2) opioid substitution therapy and other drug dependence treatment; (3) HIV testing and counselling; (4) antiretroviral therapy; (5) prevention and treatment of sexually transmitted infections; (6) condom programmes for injecting drug users and their sexual partners; (7) targeted information, education and communication for injecting drug users and their sexual partners; (8) vaccination, diagnosis and treatment of viral hepatitis; and (9) prevention, diagnosis and treatment of tuberculosis.[55]

On 27 July 2009, the UN Economic and Social Council (ECOSOC), a principal body to coordinate work in economic, social and related spheres, approved a resolution recognizing the need to:

- significantly expand and strengthen UNAIDS' work with national governments and to work with all groups of civil society to address the gap in access to services for injecting drug users in all settings, including prisons;
- develop comprehensive models of appropriate service delivery for injecting drug users;
- tackle the issues of stigmatization and discrimination; and
- increase capacity and resources for the provision of a comprehensive package of services for injecting drug users, including harm reduction programmes in relation to HIV as elaborated in the Technical Guide.[56]

A number of useful tools exist to assist with this task of legislative review and reform.[57] Complementing the *International Guidelines*, the Inter-Parliamentary Union, the UN Development Programme (UNDP) and UNAIDS have produced *Taking Action against HIV and AIDS: A Handbook for Parliamentarians*, providing detailed guidance to law-makers about factors to address and measures to include or avoid in a wide range of areas of law and policy relevant to HIV. The Handbook aims to ensure that national laws and policies are consistent with human rights obligations, and are informed by evidence and documented "good practice".[58] The Handbook points out that over 25 years into the HIV epidemic, more than "half of the countries submitting reports to UNAIDS acknowledged the existence of policies that interfere with the accessibility and effectiveness of HIV-related measures for prevention and care," and that this situation must change if countries are to meet the goal of universal access to HIV prevention, care, treatment and support (see Box 1).[59]

Box 2: Why are human rights important in responding to HIV?

"Human rights are relevant to the response to AIDS in at least three ways:

1. They decrease vulnerability to infection and to its impact. Certain groups, including people who inject drugs and prisoners, are more vulnerable to contracting HIV because they are unable to realise their civil, political, economic, social and cultural rights.
2. They decrease discrimination and stigma associated with HIV. Stigmatisation and discrimination of people living with HIV and AIDS may obstruct their access to treatment and may affect their rights to employment, housing and other rights. This, in turn, contributes to the vulnerability of others to infection, since HIV-related stigma and discrimination discourage individuals infected with, and affected by, HIV from contacting health and social services. The result is that those most needing information, education and counselling will not benefit even where such services are available.
3. They make national response more effective. Strategies to combat HIV epidemic are hampered where human rights are not respected. For example, discrimination against, and stigmatisation of, vulnerable groups such as people who inject drugs, sex workers, and men who have sex with men drives these communities underground. This inhibits the ability of social service organisations to reach those populations with prevention efforts, thereby increasing these groups' vulnerability to HIV."
   — *Taking Action against HIV: Handbook for Parliamentarians* (2007)

51 Ibid., para. 10.

52 Ibid., para. 9.

53 UNAIDS, *Practical Guidelines for Intensifying HIV Prevention: Towards Universal Access* (Geneva: UNAIDS, 2005).

54 Ibid., p. 46 (Table 2.2) and p. 53 (Table 2.9).

55 WHO, UNODC, UNAIDS, *Technical Guide for Countries To Set Targets for Universal Access to HIV Prevention, Treatment and Care for Injecting Drug Users*, 2009.

56 Economic and Social Council, *Joint United Nations Programme on Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome (UNAIDS)*), Resolution E/2009/L.23, 24 July 2009, para. 19.

57 As noted, the resource *Legislating for Health and Human Rights: Model Law on Drug Use and HIV/AIDS* (Canadian HIV/AIDS Legal Network, 2006), online at www.aidslaw.ca/modellaw, provides specific statutory provisions, based on evidence and international human rights law, to address HIV among people who use drugs, and was a key resource for the legislative review undertaken through this project. See Box 3 below.

58 Inter-Parliamentary Union, UNAIDS & UNDP, *Taking Action against HIV and AIDS: A Handbook for Parliamentarians*, No. 15/2007, online: http://www.ipu.org/english/handbks.htm#aids07.

59 Ibid., p. 70, quoting UNAIDS, *Report on the Global AIDS Epidemic 2006*.

Human rights violations negatively affect not only specific individuals, but also ultimately society as a whole. A number of key lessons have emerged from the response to HIV and AIDS to date, including the following:

- The protection of human rights is essential to safeguard human dignity in the context of HIV infection and to ensure an effective response. When human rights are not protected, people are more vulnerable to HIV infection. Where the human rights of people living with HIV (PLHIV) are not protected, such individuals are at greater risk of stigma and discrimination, and may become ill, unable to support themselves and their families; if not provided treatment, they may die.

- An effective response to AIDS requires the implementation of all human rights — civil and political, economic, social and cultural — in accordance with existing international human rights standards.

- Public health interests do not conflict with human rights. On the contrary, it has been recognised that, when human rights are protected, fewer people become infected and those living with HIV and their families can better cope with AIDS.

- A rights-based effective response to the HIV epidemic involves establishing appropriate government institutional responsibilities, implementing law reform and support services, and promoting supportive environment for groups vulnerable to HIV and those living with HIV.

- In the context of HIV infection, international human rights norms and pragmatic public health goals require States to adopt measures that may be perceived as controversial, particularly regarding the status of women and children, sex workers, people who inject drugs and men who have sex with men. It is, however, the responsibility of all States to identify how they can fully meet their human rights obligations and protect public health within their specific contexts.[60]

Too often, laws and policies that are created to protect the rights and health of people living with HIV and AIDS, and of those at high risk of HIV infection, are not implemented in reality. In fact, among people who use drugs, the right to health and other human rights are often compromised by legislation, including provisions that limit or prohibit harm reduction interventions and treatment options or access to care and treatment for prisoners or people who use drugs who are HIV-positive.[61]

Almost everywhere in the world people who use illegal drugs are often among the most marginalised and stigmatised groups of society. They are among those who are more likely to end up in prison. They are vulnerable to a wide range of human rights violations such as abusive law enforcement practices, mass incarceration and denial of health services. "People who use drugs…are portrayed by media as morally suspect or socially dead… Portrayed as less than human, drug users are thus assumed to be undeserving of human rights. Indeed, some policymakers have recommended that they be treated like drugs: as things to be isolated, controlled and contained."[62]

Prisoners are at higher risk of HIV infection, because of sharing injecting equipment and unsafe tattooing practices, and unprotected sex. Despite efforts, often very expensive, at interdiction, drugs make their way into prisons in countries the world over, and drug use in prisons, including by injection, persists. Prisoners are also exposed to HIV through sex, both consensual and non-consensual. Furthermore, in countries where people who use drugs are subject to criminal prosecution, a high proportion of them — and hence a disproportionate number of people living with HIV — are likely to end up serving a prison sentence at some point. Yet just as an emphasis on prohibiting drug use and prosecuting and imprisoning people who use drugs contributes to high rates of incarceration, legislation often also hinders the implementation of effective HIV prevention measures in prisons. Furthermore, prisoners' health care is often handled outside the regular health system. Theoretically, the same treatment protocols must be applied

60 Ibid., p. 32.

61 UNDP, *Reversing the Epidemic: HIV/AIDS in Eastern Europe and the Commonwealth of Independent States* (UNDP Regional Office for Eastern Europe and the CIS, 2004), p. 55 [hereinafter "Reversing the Epidemic"].

62 D. Barrett et al., *Recalibrating the Regime: The Need for a Human Rights-Based Approach to International Drug Policy* (London: The Beckley Foundation Drug Policy Programme, 2008).

in the penitentiary system as in the community, since it is the Ministry of Health that issues instructions and clinical protocols that are obligatory for treating certain health conditions or diseases nationwide. However, when prison medical services do not report to the Ministry of Health, the latter cannot check whether these instructions are strictly followed in prison.

As this report and the individual country reports in this publication illustrate, these observations are highly relevant to the context of the six countries of this project. As UNDP has noted, even though many countries of the region have successfully adopted human rights legislation, the gap between theory and practice remains significant, and full protection of human rights of marginalised groups at high risk of HIV transmission is not the reality. Furthermore, countries in the region continue to struggle with the legacy of the Soviet period, including poor involvement of civil society in informing public policy. Yet responses to the HIV epidemic will be most effective only if governments and communities are active in protecting the rights of the most vulnerable populations, those most at risk.[63]

In much of the region, existing legislation is often mentioned by way of explanation for the lack of more effective and evidence-based approaches and services for addressing HIV among vulnerable groups. Yet the essence of the many of these laws hindering the introduction of such measures originates in a different era with a different social, political and epidemiological situation. National legislation is not set in stone and can be changed. It must serve the purpose of protecting the rights and interests of individuals and of society in general. When legislation stops serving its purpose, it is necessary to amend it. The HIV pandemic, globally and regionally, has thrown into stark relief the damage done to individuals, to public health and to society as a whole by marginalizing, discriminating against and criminalizing entire classes of people and thereby exacerbating their vulnerability to HIV; it highlighted the urgent necessity of respecting, protecting and fulfiling human rights in order to make the response to HIV more effective. This report aims to assist governments of the six participating countries (and others) in their work to eliminate barriers for access to HIV-related services for people who use drugs and prisoners. It identifies key legislative reforms and policies that countries can and should implement to harmonise their legislation and national programmes on HIV and drugs with the Millennium Development Goals, their pledges under the 2001 *Declaration of Commitments on HIV/AIDS* and the 2006 *Political Declaration on HIV/AIDS*, the *International Guidelines on HIV/AIDS and Human Rights* and other UN documents identifying best policies and practices in responding to HIV and AIDS. Legal reform and implementation of the recommendations presented here will assist in creating an enabling legal environment for achieving the goal of "universal access" to HIV prevention, care, treatment and support.

1.3 METHODOLOGY

With the overall objective of strengthening the response to HIV-infection in Central Asia and Azerbaijan, and the specific objective of facilitating universal access to HIV prevention, care, treatment and support for people who use drugs and prisoners, an assessment of national legislation and policy in the six project countries was conducted in 2007-08. The present report is an output of the UNODC Regional Project "Effective HIV prevention, treatment and care among vulnerable populations in countries of Central Asia and Azerbaijan" (2006-2010).

The ultimate goal of the legislation assessment was to develop recommendations for national legislation amendments (or the initiation of the development of new laws, regulations and implementing documents) related to the access of people who use drugs and people in prisons to HIV prevention, treatment and care in Azerbaijan, Kazakhstan, Kyrgyzstan, Tajikistan, Turkmenistan, and Uzbekistan.

To fulfil the task UNODC Regional Office for Central Asia commissioned legal experts from the Canadian HIV/AIDS Legal Network, who served as UNODC consultants, and national experts from all countries participating in the project thus forming six national multi-disciplinary expert groups. The latter was a mix of technical experts nominated by governments/ministries, independent lawyers, and representatives of NGOs and affected communities. The UNODC Regional Project Coordinator guided and backstopped the whole process of the assessment, and national staff at UNODC Project Offices in all six countries served

63 *Reversing the Epidemic*, pp. 58-61.

as coordination focal points.
The work was done in accordance with the project's Terms of Reference, which described in detail the process of work, expected results, and the roles and responsibilities of consultants and UNODC staff.

Given the project's focus on the access to HIV-related services for people who use drugs and prisoners, the assessments and analyses examined the following legislative and normative documents:

- national programmes and strategies (and their operational plans) on HIV/AIDS and on drugs;
- criminal and administrative law;
- laws on drugs, health law, HIV/AIDS, the anti-discrimination and other relevant provisions of national laws;
- penal law;
- government regulations, guidelines and protocols in the above areas.

Special attention was given to the legislative provisions that should guarantee respect for, and the fulfilment and protection of, the human rights of people who use drugs and people in prison.

The task consisted of the following stages:

1. Assessment tool

An initial assessment tool was developed by the Canadian HIV/AIDS Legal Network for use by the national expert groups in analysing their respective countries' legislation and policy (and their application) that are of particular relevance to the response to HIV, particularly among people who use drugs and people in prison. The assessment tool was created on the basis of available guidance regarding best practices for HIV interventions and model practices for legal provisions to address HIV and drug use (see Box 3 below), taking into account characteristics of legal systems of the participating countries.[64] The assessment tool sought to assist national experts in identifying areas where aspects of national law raises human rights concerns and hinders effective HIV prevention and treatment among vulnerable populations, and in identifying potential reforms. (The assessment tool is reproduced in Appendix 2.)

2. Training of national expert groups

The national expert groups participated in a weeklong training session in Almaty, Kazakhstan in July 2007 delivered by two legal experts of the Canadian HIV/AIDS Legal Network and UNODC staff. The training focused on international human rights law and current developments in the area of HIV prevention and treatment for people who use drugs and prisoners, with special attention to techniques of legislation analysis and assessment. (The training module used in this session, which may be of use in other similar projects, is appended to this report as Appendix 3).

3. National assessments and reports

Using the assessment tool and materials provided, the national expert groups reviewed the relevant legislation and normative documents in their own countries. With multiple rounds of exchange of information, specifications and comments among the Legal Network, UNODC and the national expert groups, the latter prepared an extensive compilation of information as the product of the national assessments and drafted recommendations for legislative amendments. Based on information provided by the national expert groups and UNODC, and supplemented by additional research and drafting, the Canadian HIV/AIDS Legal Network elaborated the content and prepared a summary report for each country. Those reports include specific recommendations reflecting the current legislative and policy situation in each country. The six country reports are presented in Part II of this publication.

4. Integrated report

Drawing on the summary reports for each of the six countries, supplemented by additional information provided by UNODC and further research and analysis, the Canadian HIV/AIDS Legal Network prepared the integrated report, constituting Part I of this publication. This integrated report situates the legislative review project in a regional context, analyses the common themes and key findings from the country assessments and highlights recommendations of broad relevance to the project countries and several recommendations to the international organizations working in the region

5. Check-list for self-assessment

Based on the questions and recommendations for reforms that had arisen in the course of the national assessments, the Canadian HIV/AIDS Legal Network, with input from and discussions with UNODC and the expert groups, prepared a 100-question check-list for countries to rate their progress toward reforming key aspects of national law, policy and practice affecting the response to HIV as it relates to vulnerable populations, particularly people who use drugs and people in prison. (The check-list is in Appendix 4.)

6. Presentation of project results

Draft country reports have been presented to, discussed with and commented upon by national stakeholders (parliamentarians, ministerial staff, NGOs representatives) in all six countries. In addition, results of the review and analysis of legislation, policy and practice in the six countries, and recommendations for reform, have been presented in various international and regional fora, and served as a basis for informing regional and country-level discussions with legislators and policy-makers for implementing selected reforms. Even before the release of this publication, the project has already stimulated legislative amendments in the region. This publication provides a basis for continued reforms to strengthen the participating countries' response to HIV as it relates to drug users and prison inmates, the two particularly vulnerable populations, and thereby contributes to achieving universal access to HIV prevention, care, treatment and support.

Box 3: *Legislating for Health and Human Rights: Model Law on Drug Use and HIV/AIDS*

The model law is a resource prepared by the Canadian HIV/AIDS Legal Network in 2006 following extensive consultation with stakeholders around the world. It is a detailed framework of legal provisions and accompanying commentary addressing HIV prevention and treatment among people who inject drugs. It refers to examples of law from jurisdictions that have attempted to establish a clear legal framework for addressing HIV and AIDS issues among people who use drugs. This resource also incorporates human rights principles and obligations of states throughout the document.

The model law resource is designed to inform and assist policy-makers and advocates as they approach the task of reforming or making laws to meet the legal challenges posed by the HIV epidemic among people who use drugs. This resource can be most useful for those countries where injection drug use is a significant factor driving the HIV epidemic, and particularly for developing countries and countries in transition where legislative drafting resources may be scarce.

Legislating for Health and Human Rights consists of the following eight modules, each of which is a stand-alone document:

1. Criminal law issues
2. Treatment for drug dependence
3. Sterile syringe programmes
4. Supervised drug consumption facilities
5. Prisons
6. Outreach and information
7. Stigma and discrimination
8. Heroin prescription programmes.

The complete set of modules is available at www.aidslaw.ca/modellaw (in English) and www.aidslaw.ca/modellaw-ru (in Russian).

64 As requested by UNODC, this assessment tool was based in part on Legislating for Health and Human Rights: Model Law on Drug use and HIV/AIDS (Canadian HIV/AIDS Legal Network, 2006), online www.aidslaw.ca/modellaw.

2. PROJECT COUNTRIES: AN OVERVIEW

As noted, this project identifies aspects of law and policy that are of particular relevance to addressing HIV infection among people who use drugs and prisoners. This chapter provides a summary overview of the regional context in which this project was undertaken: it introduces the extent of problematic drug use and of the HIV epidemic and related health concerns in the countries, and describes in general terms the political, legal, health care and criminal justice systems that must be engaged in making legislative and policy reforms to strengthen HIV prevention, care, treatment and support among vulnerable populations, and in particular people who use drugs and prisoners.

2.1 POPULATION AND GEOGRAPHY

The five Central Asian countries and the southern Caucasian country of Azerbaijan differ considerably in size, natural resources, political orientation and other indicators. Nevertheless, they share many characteristics in part as a result of their common history as former republics within the USSR. In addition, Azerbaijan shares common ethnic Turkic and Islamic religious roots with the Central Asian countries, as well as close historical contacts and energy and environmental connections through the Caspian Sea.[65]

The total population of the Central Asian countries and Azerbaijan was approximately 70 million as of the middle of 2009.[66] Kazakhstan is the largest of the project countries by land mass, but with a population of only just over 15.8 million, has the lowest population density. It is also the wealthiest, accounting for just over half of the aggregate regional GDP, most of which derives from large petroleum reserves. Uzbekistan has the largest population (27.5 million), representing 45% of the entire population of the region. Kyrgyzstan and Turkmenistan have populations of similar size (5.3 million and 5.1 million respectively), but there are few other similarities between them: Turkmenistan is an arid country with vast energy reserves, especially of natural gas, while Kyrgyzstan is a small mountainous country with few natural resources other than water resources. Mountainous and landlocked, with a population of 7.4 million, Tajikistan is the smallest country by territory in Central Asia; aluminum production is a major industry and its many rivers hold potential for hydroelectric power as a commodity. Azerbaijan has the smallest land mass of the project countries and a population of 8.7 million.

2.2 DRUG USE

According to the UN, Central Asia as a region experienced a 17-fold rise in drug use from 1990 to 2002 (and especially of heroin injection), the highest growth rate in the world during that period.[67] The number of people undergoing drug dependence treatment in Tajikistan quadrupled over the period from 1996 to 2000; health care experts have suggested the real number of people who use drugs may be 10-15% higher.[68] In Turkmenistan, the number of people using drugs registered at narcological services increased approximately 8-fold between 1991 and 2001.[69] Between 1991 and 2001, in Kyrgyzstan, the number of people using drugs increased by 340%.[70] UNDP has reported that drug use has become increasingly dangerous, with poor quality heroin administered intravenously being the most commonly used.[71] In addition, the average age of those using drugs has fallen, while the proportion of people with drug dependence who are women has increased (as has the number of women arrested for involvement in drug trafficking, which has quadrupled from 1993 to 1998).[72]

65 UNDP, *Central Asia Human Development Report 2005*, p. 23.

66 Population Reference Bureau Data as of mid-2009; see www.prb.org.

67 UNDP, *Central Asia Human Development Report 2005*, p. 122.

68 Ibid.

69 Ibid. Historically, opium use administered orally or smoked was a quasi-acceptable behaviour in Turkmenistan. Since the 1970s, drug use patterns have been changing but even now Turkmenistan is different from other Central Asian countries in that smoking heroin (and to a lesser extent raw opium), rather than injecting , especially in rural area, remains a predominant mode of drug use. However, as observers note, this is probably not reflective of effective education about the risks of injection, such as HIV and other blood-borne diseases, but rather of the level of heroin and opium availability and affordability, which is the result of the complex interplay of socio-political, economic and cultural factors. For more discussion, see: N. Kerimi, "Opium Use in Turkmenistan: A Historical Perspective," *Addiction* 2000; 95(9): 1319-1333.

70 UNDP, *Central Asia Human Development Report 2005*, p. 122.

71 Ibid., p. 123.

72 Ibid.

A history of drug use is common among people imprisoned in the project countries, as is injection drug use in prisons. Some 60% of prisoners in Kyrgyzstan reported using drugs while incarcerated, with the majority injecting.[73] Sharing needles is a common practice: many prisoners reported lending, renting or selling their used needles to others for injecting.[74] Getting tattoos in prison is another common practice: among prisoners interviewed in three countries (Kyrgyzstan, Tajikistan and Uzbekistan), roughly 17% of the prison population in each country had received a tattoo while in prison, most of them with needles that had been used previously.[75] While prisoners have sex in prisons, a very small number of prisoners reported using condoms.[76]

2.3 HIV EPIDEMIC

Until 1994, there had been few registered cases of HIV infection in the countries of the region.[77] However, HIV is now spreading in the region more rapidly than in many other parts of the world. While there were only 50 HIV cases in 1996, 8,078 cases had been registered by 2004,[78] and there was a 1600% increase in HIV prevalence between 2002 and 2004.[79] All six of the project countries are now experiencing HIV epidemics concentrated among people who inject drugs and their sexual partners, sex workers, and to a lesser degree, among men having sex with men.[80]

The single largest driver of the epidemic in the region is unsafe injecting practices widespread among people who use drugs. An estimated 85% of HIV infections in Central Asia occur among injection drug users.[81] According to data published by UNDP, levels of awareness of the risk of HIV infection through sharing needles and other items is limited among both people who use drugs and the population in general. More than 60% of those in Uzbekistan living with HIV are people who inject drugs. In several regions in Azerbaijan, Kazakhstan, Kyrgyzstan and Uzbekistan, an estimated 30-40% of injection drug users have contracted HIV.[82]

At present, Uzbekistan shows the highest prevalence in Central Asia, with newly registered HIV cases rising exponentially from 28 cases in 1999 to 1,836 cases in 2003. Since then, the number of HIV cases newly registered each year has been rising more slowly; there were 2,205 people newly diagnosed as HIV-positive in 2006. Over the period from 2002 to 2006, the annual number of newly registered HIV cases among people who inject drugs more than doubled, from 631 to 1,464.[83] In Kazakhstan, the number of newly registered HIV cases increased from 699 in 2004 to 1,745 in 2006, and two-thirds (66%) of new HIV cases in 2006 were registered among people who inject drugs.[84] The HIV epidemics in Kyrgyzstan and Tajikistan are also primarily caused by injection drug use, but currently much smaller in scope than those in other countries in the region. Tajikistan shows an annual increase of newly diagnosed HIV cases from seven cases in 2000 to 41 cases in 2003 and 204 cases in 2006. In Kyrgyzstan, there were 16 cases in 2000, which figure rose to 132 cases in 2003 and 244 cases in 2006. Almost half (47%) of all HIV cases registered in Azerbaijan, where the epidemic is relatively new, were identified in 2005-2006.[85] In sharp contrast to the rest of the region, official reports claim only two HIV cases in Turkmenistan.[86]

HIV prevalence in prisons is a major concern for countries in the region, with injection drug use and the prohibitive legal approach towards it — which results in many people who use drugs being imprisoned

73 UNODC & World Bank, *Regional Study on Drug Use and HIV/AIDS* (2007), p. 36.

74 Ibid., p. 52.

75 Ibid.

76 Ibid.

77 *Reversing the Epidemic,* p.11.

78 UNDP, *Central Asia Human Development Report 2005*, p. 146.

79 Ibid.

80 UNAIDS, *Eastern Europe and Central Asia: AIDS Epidemic Update Regional Summary* (2007).

81 UNDP, *Central Asia Human Development Report 2005*, p. 123.

82 Ibid.

83 UNAIDS, *Eastern Europe and Central Asia: AIDS Epidemic Update Regional Summary*, p. 6.

84 Ibid., p. 7.

85 Ibid., p. 9

86 Ibid, p. 8.

— as primary factors. In Tajikistan, HIV prevalence was reported at 6.2% among prisoners in institutions in Dushanbe and Khujand in 2005, and at 8.4% in 2006;[87] in 2005, there were 23 cases of HIV recorded in Tajik prisons, 95% of them among injection drug users.[88] In Kyrgyzstan, all 39 HIV cases recorded in 2005 among prisoners were among injection drug users; the reported cumulative number of HIV cases in Kyrgyzstan's prisons is 277, almost 120 times the national average.[89] According to most recent figures from UNODC, estimated HIV prevalence among prisoners in Kyrgyzstan is 3.5% and the estimated prevalence of hepatitis C virus (HCV) is 40.3%.[90] In Azerbaijan in 2007, HIV diagnosed in 132 prisoners out of 5,663 tested (2.3%). According to UNODC, 72% of people living with HIV in Azerbaijan have a history of imprisonment.[91]

TABLE 1: Overview of drug use, prevalence of HIV infection and hepatitis C (HCV) in project countries[92]

Country and population (millions)	Est. no. of IDUs	Est. no. of people with HIV	HIV prevalence among adults (age 15-49)	HIV prevalence among IDU	HCV prevalence among IDU	% of IDU among all HIV+	No of people on ARVs; and est. ARV coverage
Azerbaijan 8,500[a]	21,189 people (374 women) registered as drug-dependent as of 2007[a] 80,000[b]	7,800 (range 4700-16000 as of 2008) [g]	0.2% (0.1-0.3%)[g]; 23.9 per 100.000 popn.[a]	19-24% [b]	57% [b]	57.7% (2007) [a]	< 100; 6-24% (2007) [h]
Kazakhstan 15,532[c]	186,000[b]	12,000 range 7.000-29.000 [g]	0.1% (0.1-0.3%)[g]; 54.0 per 100,000 [h]	3.9% [b]	65.7% [b]	72.7 [g]	< 500; 14-36% (2007) [h]
Kyrgyzstan 5,376[c]	5,387 (registered)[a] 44.000[b]	4,200 (1479 registered, 326 women, as of 2008)[a]	0.1% (0.1-0.3%)[g]; 26.1 per 100,000 popn.[a]	1039 people (~ 7.4%)[a] 3-9%[b]	50.6%[a]	72%[a]	< 100; 8-26% (2007) [h]
Tajikistan 6,839[c]	15,000[b] 34,000 [d] (2007)	1153 [a] 10,000 (5,000-23,000) [g]	0.3% (0.1-0.6%); [g] 15.5 per 100,000.[d]	663 (57%)[a] 23.5%[b]	43.4%[b]	57.9% [d] 92007)	<100; 4-11% (2007) [h]
Turkmenistan 5,031[c]	11,148[b]	2 [f]; < 1000[a]	<0.1	n/a	n/a	n/a	0
Uzbekistan 27,769[c]	80,000[a] (15% women)	16,000 (8,100-45,000) [g]	0.1% (0.1 – 0.3%)[g]; 11.7 per 100,000.	15.33%[b]	5% [b]	11.7%[a] 45% (2006)[f]	<500; 9-51% (2007) [h]

87 National progress report on the Declaration of Commitment on HIV/AIDS to the Special Session of the UN General Assembly: Tajikistan (2007), p. 9.

88 UNODC, *Regional Study on Drug Use and HIV/AIDS* (2007), p. 36.

89 Ibid., pp. 36, 40.

90 Official data provided by UNODC National Project Officers [on file].

91 Official data provided by UNODC National Project Officers [on file].

92 Table shows sources for data as follows: (In cases where sources showed significant discrepancy in numbers, two sources are presented.)

[a] Official data provided by UNODC National Project Officers [on file].

[b] C. Cook & N. Kanaef, *Global State of Harm Reduction 2008: Mapping the response to drug-related HIV and hepatitis C epidemics* (London: International Harm Reduction Program, 2008).

[c] UNODC, *Compendium of Drug Related Statistics* (2008).

[d] UNAIDS, Tajikistan, country progress report (January 2008); Uzbekistan country progress report (2008).

[e] UNAIDS, *Eastern Europe and Central Asia: AIDS Epidemic Update Regional Summary* (2007).

[f] Data submitted by national expert group of relevant country in preparing individual country reports.

[g] UNAIDS country response pages, available via http://www.unaids.org/en/CountryResponses/Countries/default.asp (last accessed 22 June, 2009).

[h] Country Epidemiological Fact Sheets on HIV and AIDS, 2008 update, available via http://www.unaids.org/en/CountryResponses/Countries/default.asp (last accessed 22 June, 2009).

2.4 GOVERNMENT AND GENERAL LEGAL SYSTEMS

Despite changes since achieving independence, the legal and government systems of states that were formerly part of the Soviet Union are still similar in many respects. Azerbaijan, Kazakhstan, Tajikistan and Uzbekistan are presidential republics with bicameral parliaments elected for a five-year period, while Kyrgyzstan and Turkmenistan have unicameral parliaments. Presidential power is strong in all six countries. In Kyrgyzstan, the president is elected by nationwide vote for a 5-year term, and, as a rule, with a limit of two consecutive terms. In Azerbaijan, Tajikistan and Turkmenistan, presidents are elected for five-year terms, with a limit of two terms in Azerbaijan and Tajikistan and no constitutional limit on terms in Turkmenistan. In Uzbekistan and Kazakhstan, the president is elected for 7 years and in Kazakhstan there is no limit for re-election.

Azerbaijan is the only one of the six project countries that is a member state of the Council of Europe and has hence signed and ratified the *European Convention on Human Rights*.[93] All six countries are member states of the Organization for Security and Cooperation in Europe (OSCE). All of them are member states of the UN and have ratified the main international conventions on human rights.[94] All of the project countries are member states of the Commonwealth of Independent States (CIS), the regional organisation composed of numerous former Soviet republics (although note that Turkmenistan reduced its status to being only an associate member in 2005, rather than remain a full member state). The countries have concluded a number of bilateral and multilateral agreements and treaties on cooperation to combat illegal drug trafficking.

All six of the project countries proclaim the primacy of international law, including ratified international treaties, over national legislation.[95] In each country international treaties automatically come into force upon ratification by a country's Parliament;[96] the adoption of a new act introducing the treaty's provisions into national legislation is not required. All legislation related to human rights and freedoms is subject to mandatory publication for access by the general public; otherwise, it is invalid. All the project countries have continental/civil legal systems, as opposed to common law systems, meaning there is little or no role for judicial precedents.

The Constitution of each of the project countries contains a broad range of human rights and freedoms. The legislative hierarchy consists of the Constitution at the apex, under which sit "codes" and "laws" (provisions that regulate distinct legal spheres), which are further supplemented by subsidiary instruments such as regulations, decrees, orders and instructions (e.g., by the President, by the Government as a whole, or by a minister).[97]

National laws are often broad, declarative and contain norms to be spelled out in more detail via other (subordinate) legislation. Therefore, regulations and instructions made by the bodies of executive branch of government (e.g., presidential, cabinet or ministerial decrees, orders or regulations) may sometimes interpret the statutes adopted by the legislature in ways that limit human rights and freedoms.[98]

Judicial power is exercised through civil, criminal and other proceedings (i.e. constitutional, administrative, economic). As a rule, a public defender is guaranteed for the accused person in the majority of criminal cases and court proceedings are public and open. There are courts at the levels of the city district, city, region (or equivalent), courts of appeal and supreme courts. Azerbaijan allows the existence of specialized

93 Azerbaijan joined the Council of Europe on 25 January 2001 and ratified the *European Convention* on 15 April 2002.

94 For a complete list of UN human rights treaties and the status of their ratification by various countries, see the website of the Office of the UN High Commissioner for Human Rights (www.ohchr.org).

95 E.g., *Constitution of the Azerbaijan Republic* (12 November 1995), Article 151.

96 E.g., *Constitution of Kazakhstan* (30 August 1995), Article 4.

97 E.g., see the *Law "On Regulatory and Legal Acts of the Republic of Uzbekistan,"* Law No. 160-II (14 December 2000), Article 14, or Kazakhstan's *Law "On Regulatory and Legal Acts,"* Law No. 213-1 (24 March 1998).

98 For instance, the national law on HIV may state that discrimination against people living with HIV is prohibited, except for cases listed in special corresponding legislation. But a regulation — or often several regulations — then lists situations in which the rights of people living with HIV are or may be limited. Such limitations of rights may fail to take into account the epidemiological situation and the broader implications for public health, as well as the rights and freedoms of individuals. Moreover, legislation prohibits discrimination, while regulatory acts define and broaden it, thus contradicting country's Constitution and international legal obligations. They may also contradict the rule in accordance with which limitation of rights is permissible only by statute and not by regulatory acts: e.g., *Constitution of Kazakhstan*, Article 39(1).

courts: Constitutional, supreme and appellate courts and courts of general jurisdiction function along with the courts for serious offences, military tribunals and local economic courts (which hear contract and commercial disputes). Kyrgyzstan has also established specialized courts. All of the project countries except Turkmenistan have Constitutional Courts, which provide interpretation of the Constitutions and other laws and can adjudicate the constitutionality of other legal provisions. Kazakhstan established a Constitutional Council in place of the Constitutional Court with similar functions.[99]

2.5 CRIMINAL JUSTICE SYSTEMS

In the project countries, the criminal justice system is governed by a *Criminal Code*, *Criminal Procedure Code* and/or *Penal Code* as well as other legal acts and regulations.

Pre-trial investigation by law enforcement authorities is required for all criminal cases except for cases of minor social importance, which category does not include drug offences. Persons charged with or suspected of a criminal offence may be held in pre-trial detention (investigative detention before charges based upon suspicion of committing an offence is supposed to be limited to a short period of time such as a few days at most; detention after the charges are laid can be considerably longer.) Accused may be conditionally released and restricted to their place of residence pending trial; those on conditional release sign a "promise letter" that they will not leave an area around their residence.

In all six project countries, the state is required to provide free legal aid to the accused in criminal procedures for those who cannot otherwise afford one, and in certain cases when participation of a defence lawyer is mandatory. By law, if the accused person is disabled, is a minor, is not in a position to represent his or her interests, simply requests a defence lawyer, or is charged with a serious crime with a lengthy sentence the government must provide a state-appointed public defender.[100] As with other offences, persons accused of drug offences may be eligible for free legal aid. In certain cases, persons facing compulsory drug dependence treatment are automatically supposed to be provided with free legal aid (e.g., Azerbaijan, Turkmenistan).

In Azerbaijan, Kyrgyzstan and Tajikistan, legal aid functions are sometimes performed by NGOs which provide some free legal assistance to low-income persons. For example, in Tajikistan free legal aid bureaus have been established in larger cities with the assistance of international organizations. In some cases, bar associations, chairs of legal aid offices or law firms may decide to provide services *pro bono* based on a person's financial situation.

In Tajikistan, Turkmenistan and Uzbekistan, criminal cases of the first instance are heard by a judge and two lay assessors (*"narodnie zasedateli"*). In more serious criminal cases, the trial proceeds in front of a panel of three judges.

Trial by jury (*"prisyazhnie zasedateli"*) is not established in Uzbekistan, Tajikistan or Turkmenistan. However, in Azerbaijan, Kazakhstan and Kyrgyzstan the Soviet concept of lay assessors ("*narodnie zasedateli"*) was abolished and trial by jury established. In these countries, the trial of the first instance proceeds in front of either a single judge or a panel of three judges. In Azerbaijan, trial is by jury in cases where the accused person faces a possible sentence of life imprisonment or for certain more serious charges (including some drug offences), and upon the accused person's request for a jury trial. In Kazakhstan, jury trials are held in cases of more serious offences and upon the request of an accused. Appeals in all six countries are heard by a panel of three judges or more.

99 *Constitution of Kazakhstan* (30 August 1995), Chapter VI.

100 For example, Article 51 of Azerbaijan's Criminal Procedure Code requires the participation of a defence lawyer in criminal proceedings in the following circumstances:
suspect or accused requests a defence lawyer;
suspect or accused is a minor;
because of physical or mental disability, the suspect or accused is not in a position to manage own defence;
suspect or accused does not speak the language of a criminal proceeding;
person is accused of serious offence;
suspect or accused is a military conscript;
suspect or accused is involuntarily placed into a specialized medical facility.

2.6 HEALTH CARE SYSTEMS

All the project countries have inherited health care systems with similar centralized structures and management systems founded on the Soviet system. In each country, the Constitution guarantees free health care services to some extent, but there is considerable evidence of a significant gap between proclaimed legal guarantees and the reality.[101] Some of the national expert groups participating in this project have reported that persons seeking medical care often have to pay for medical supplies, meals, linen, prompt admission to hospital and better quality services.[102]

Access to free health care is provided in district health care facilities on the basis of one's proof of residence (i.e. registration at a particular address). This system can present a potential problem for persons without such a certificate establishing a place of residence, most obviously homeless persons and migrants. In the absence of producing such a certificate, health services are provided on a fee-for-service basis only (with the exception of emergency care).

HIV prevention and treatment

All of the project countries have special AIDS centres responsible for HIV prevention and treatment. These bodies were established in the early 1990s; while the approach seemed progressive at the time, doubts have since been raised about its efficacy.[103] One concern is that it singles out HIV from the broader system of public health care and impedes the integration of HIV-related services with services for the prevention and treatment of tuberculosis, drug dependence and hepatitis. Some concerns have been also raised that designating separate centres as those with the responsibility for responding to HIV, and relieving other parts of the health care system and other health care workers from dealing with HIV infection, may further aggravate stigma and discrimination against people living with HIV and AIDS and those vulnerable to infection.

Each project country has public health legislation governing relationships in the sphere of health care, including the right to free health care services. These laws define such concepts as "diseases posing a threat to others" and "socially significant diseases",[104] which categories exist in the laws of all of the project countries except Kyrgyzstan. All of the project countries adopted specific statutes on HIV and AIDS in the mid-1990s, generally modelled on the Soviet Union's 1990 law (see Box 4).[105] These laws regulate the rights and responsibilities of persons with regard to HIV infection and AIDS, and the mandate, obligations and privileges of health care workers and bodies working in the area of HIV. All of the laws contain anti-discrimination provisions and provisions on the confidentiality of medical information.[106] However, there have been few cases of launching legal proceedings for breaches of such provisions, such as health care workers disclosing a patient's confidential HIV diagnosis.[107]

In all the project countries (except for Kyrgyzstan) the national law on HIV and/or subsidiary regulations adopted under it contains very broad provisions on compulsory and mandatory HIV testing for various categories of people.[108] Although some project countries have implemented voluntary HIV testing and counselling services, often these are not formally reflected in or required by the law. In addition, the law or accompanying regulations often unjustifiably infringe the rights of people living with HIV and AIDS in discriminatory ways (e.g., prohibitions on military service, prohibitions on employment in specified professions or occupations, denial of adoption of a child or interference with family relations).[109]

101 E.g., see: UNDP, *Reversing the Epidemic* (2004), *supra*; Human Rights Watch, *Fanning the Flames: How Human Rights Abuses are Fuelling the AIDS Epidemic in Kazakhstan* (2003), *supra*.

102 E.g., see country reports prepared by national experts groups from Uzbekistan and Kazakstan (full versions, in Russian only) [on file].

103 Kazakhstan created the first such centre in 1992, and at this writing, its system comprised 16 regional centres and 6 city centres. Kyrgyzstan established a national AIDS agency in 1994. Tajikistan's system consists of a National Centre for AIDS Prevention and 4 regional, 3 city and 7 district centres. In Turkmenistan since 1989, there is one national centre and five oblast centres for HIV prevention with offices for HIV counselling and testing.

104 These provision derive from the "Framework Law of the USSR and Soviet Republics on Health Care" [Основы законодательства Союза ССР и союзных республик о здравоохранении] (1969), which categorized chronic alcohol and drug dependence as diseases posing a threat to other people (along with such conditions as leprosy, venereal diseases and infections for which people could be quarantined).

105 See individual country reports in Part II for details.

106 E.g. , Tajikistan's HIV law requires mandatory HIV testing of foreigners and blood donors, and subsequent regulations further provide for mandatory HIV testing for pregnant women, people who inject drugs and other population groups. See Tajikistan country report in Part II below.

107 For one such report, see: L. Utyasheva, "First HIV legal precedent in Kyrgyzstan: breach of medical privacy," HIV/AIDS Policy and Law Review 2007; 12(2/3): 70, online via www.aidslaw.ca/review.

108 For more detail, see Section 4 below.

109 For more detail, see Section 5 below.

Box 4: USSR's Law "On Prevention of AIDS "

The USSR's *Law "On Prevention of AIDS "* of 1990[110] contained general provisions on the rights of people living with HIV in relation to care, treatment and support. This included free medication and coverage for the costs of travel to and from treatment sites. Parents and caregivers were entitled to accompany patients in hospital and receive sick leave compensation for this purpose. People with HIV were also entitled to a pension if infection occurred in a medical facility.

The law also included general anti-discrimination provisions prohibiting an employer from refusing to hire, or dismissing, a person based on HIV-positive status, as well as prohibiting nurseries and educational institutions from refusing to admit children and students with HIV. The law guaranteed protection of other rights and did not permit limitations on rights of people living with HIV on the basis of HIV status or AIDS diagnosis, and also protected the rights and interests of family members and relatives. However, these provisions concerning protection from discrimination and other human rights remained largely on paper.

Drug dependence treatment (narcological assistance)

In the project countries, treatment for drug dependence is provided in narcological hospitals and in narcological offices in general hospitals. Treatment for drug dependence is generally free, except for Kyrgyzstan where such treatment is provided on the basis of a co-payment by the patient.

In accordance with the Soviet-era narcological system, treatment is based on detoxification with the limited use of rehabilitation and psychological methods (see Box 5). However, other approaches that rest on the recognition that drug dependence is a health condition (rather than conceiving of it primarily in criminal terms), have faced difficulty gaining acceptance even in the post-Soviet environment. At this writing, despite solid evidence gathered over decades in other jurisdictions and endorsement by the UN's specialized technical agencies, opioid substitution therapy (OST) has been implemented only in three of six project countries (Azerbaijan, Kyrgyzstan, Kazakhstan), where the coverage of the services remains limited. Among all the countries that have taken part in the project, Kyrgyzstan was the first to implement opioid substitution treatment in 2002. In Tajikistan, according to government information, OST pilot projects are planned for the near future. In Uzbekistan, OST was available as of 2004, but in 2009 the government discontinued the pilot project. OST is not available in Turkmenistan.

Box 5: Narcology in the Soviet era[111]

The division between psychiatry and narcology (alcohol and drug dependence treatment) in the project countries dates back to the Soviet era. This division between fields of practice took place in 1976 and was designed to improve the management of psychiatric care and to boost the development of treatment for alcohol and drug dependence, particularly given the rise in alcohol misuse. The objectives included early detection, registration, treatment and prevention of alcohol and drug dependence. The guiding principle of this system was preventive health assessment of the population — in other words, active surveillance and treatment. Doctors were given the task of detection and mandatory referral to treatment in narcology of those who were deemed dependent on drugs or alcohol.

Compulsory treatment

The concept of compulsory treatment dates back to the "Framework Law of the USSR and Soviet Republics on Health Care" (1969), which identified circumstances and procedures for treatment of persons suffering from chronic drug or alcohol dependence to hospitals. In the event a drug-dependent person refused to undergo voluntary treatment, he or she could be ordered by court into compulsory treatment at medical-labour centres under the purview of the Ministry of Internal Affairs. The legal status of people in compulsory treatment facilities was similar to that of prisoners, and the regime in treatment-labour centres was similar to that in prisons. Escaping from such a facility, or en route to it, was treated as equivalent to escape from prison and could, if recaptured, trigger a prison sentence.

110 Union of Soviet Socialist Republics, *Law "On Prevention of AIDS Disease"* [О профилактике заболевания СПИД], Law No. 1447-1 (23 April 1990).

111 Organization for Chemical Dependence Assistance in Russian Federation, Drug Control No. 4 (2007); V. Mendelevich, "Involuntary (forced) and alternative treatment of drug dependence: theoretical and practical questions for discussion," Narcology # 7 (2007).

Patients had no right of appeal from a court decision ordering them into compulsory treatment or extending or reducing a treatment period, nor did they have a right to legal counsel.

The system of compulsory treatment in the Soviet Union ceased to exist after the Constitutional Oversight Committee of the USSR declared the system unconstitutional in 1990, shortly before the project countries achieved independence.[112] The Committee ruled that that neither the USSR Constitution nor international human rights norms provided that people had an obligation to take care of their own health, and thus this obligation could not be "ensured by compulsory means." The Committee concluded that "treatment of patients with alcohol dependence who did not commit offences should be carried out on a voluntary basis."

Patient confidentiality

In 1979, the Ministry of Health of the USSR adopted its Instruction "On the procedure of informing about the mental health of the population." This instruction prohibited disclosure of information about patients with mental health disorders and their diagnoses to anyone with the exception of the law enforcement agencies and the courts. However, in the case of patients with alcohol or drug dependence, physicians were only obliged to maintain patient confidentiality if the patient critically assessed his or her condition (aware of his/her dependence), was determined to get treatment and carefully followed all medical prescriptions.

Harm reduction programmes

Kyrgyzstan was the first country in the region to establish harm reduction programmes when it launched needle exchange programmes in Bishkek and Osh in 1999.[113] At this writing, needle and syringe programmes exist in five of the six project countries; Turkmenistan is the exception.

In none of the countries, however, have these interventions been entrenched in law. The breadth and depth of provisions on HIV prevention as it relates to drug use in the national anti-drug strategies of the project countries vary, but these documents do not define the legal status of HIV prevention programmes for drug users. In Kazakhstan, certain harm reduction interventions are implemented at "trust points", facilities whose existence is governed by implementing regulations. The lack of a clear legislative framework leaves such health services in a more precarious position, more easily susceptible to changes in the political environment, rather than being established firmly as core health services that should be taken as a given.

2.7 CORRECTIONAL SYSTEMS

In the Soviet Union, correctional facilities were under the control of the Ministry of Internal Affairs. This system is still in place in Turkmenistan and Uzbekistan, while in Azerbaijan, Kazakhstan, Kyrgyzstan and Tajikistan responsibility was transferred to the Ministry of Justice during reforms in the early 2000s.

Health care services in prisons are provided by health care departments within the relevant Ministry with overall responsibility for the prison system. According to the law in each of the project countries, prisoners with HIV are to receive ARV therapy. However, interviews conducted by the national expert groups demonstrated that health care services in prison are not equal to the services provided in the community outside: prisoners reported that they often have to purchase medicine, or rely on relatives and friends to buy medicine for them, because medical departments in prisons did not have them.[114]

Prisoners with HIV are held together with the rest of the prison population. Prisoners with tuberculosis are detained separately in all of the six project countries.

112 Constitutional Oversight Committee of the USSR, "On legislation regarding compulsory treatment and labour re-education of people dependent on alcohol and drugs" [Заключение Комитета конституционного надзора СССР «О законодательстве по вопросу о принудительном лечении и трудовом перевоспитании лиц, страдающих алкоголизмом и наркоманией»], Decision No. 8 (25 October 1990).

113 D. Wolfe, *Pointing the Way: Harm Reduction in Kyrgyz Republic* (Harm Reduction Association of Kyrhyzstan, 2005).

114 E.g., see the Kygyzstan country report in Part II for more detail.

The project countries vary in the degree to which they have responded to the risks of infectious diseases, including HIV, in prisons and to the need to provide health services for prisoners. In most of the project countries (Azerbaijan, Kazakhstan, Kyrgyzstan and Tajikistan) prison authorities have recognized the reality of sexual activity and drug use in prisons and pre-trial detention facilities, and are now implementing HIV prevention interventions. Official reports from Turkmenistan state that there is no drug use in its prisons, nor are there any cases of HIV infection.

According to the national expert groups, educational information on HIV prevention is distributed in prisons in all of the project countries. Condoms are distributed to prisoners in only three countries (Kazakhstan, Kyrgyzstan and Tajikistan). In other three countries condoms are available in the rooms for conjugal visits only.

In 2000, Kyrgyzstan was among the first countries in the Commonwealth of Independent States (CIS), along with Moldova, to introduce needle and syringe programmes in prisons — the programmes whose importance and efficacy is increasingly documented and recognized internationally by a growing number of countries as part of good, comprehensive practice in responding to HIV in prisons.[115] However, legal provisions exist in almost all the project countries that prohibit prisoners from possessing objects that can be used for cutting or piercing (although there is no explicit mention of needles and syringes). Only in Kyrgyzstan, after the recent amendments to the internal prison rules, is possession of syringes and needles no longer forbidden for people in the correctional system.[116] In three project countries (Kazakhstan, Kyrgyzstan, Tajikistan), prisoners have access to disinfectants; while important, this is not considered a satisfactory substitute for access to sterile drug injection or tattooing needles.[117] As of August 2008, pilot projects providing opioid substitution treatment (using methadone) were underway in prisons in Kyrgyzstan,[118] but none of the other project countries had implemented access to OST in prisons.

As noted above, legislation in all of the project countries authorizes compulsory drug dependence treatment in prisons, but the implementation of such treatment varies. Meanwhile, effective voluntary treatment for drug dependence in prison is not always accessible to patients in need.[119]

2.8 HUMAN RIGHTS SITUATION: HIV, DRUG USE, PRISONS

In each of the project countries, all legislation that deals with human rights must be published or it becomes legally invalid.[120] Human rights guaranteed by the Constitution have direct effect and theoretically need not be specified in other legislative acts.[121] The executive, the judiciary and the public prosecution authority are all obliged to respect and protect human rights. Specialized agencies, such as Commissioners for Human Rights (ombudsmen) or Human Rights Commissions under the president (e.g., in Kyrgyzstan and Azerbaijan) are established to process complaints alleging human rights infringements by government agencies. There are no specialized agencies dealing specifically with protection from discrimination in any of the countries.

Most of the project countries have ratified human rights treaties that create a right of individual complaint to an international mechanism. For example, with the exception of Kazakhstan, the project countries have ratified the Optional Protocol to the ICCPR (which allows for complaints to the UN's Human Rights Committee); Azerbaijan has also ratified the *European Convention on Human Rights*. However, according to the national expert groups, there have been no complaints and communications under these treaties to the relevant bodies regarding such matters as discrimination based on health status or the denial of adequate medical care or treatment in prisons. Yet, as the national expert groups have reported, people

115 Wolfe, Pointing the Way, supra, p. 9; R. Lines et al., Prison Needle Exchange: Lessons from a Comprehensive Review of International Evidence and Experience (2nd ed.), (Toronto: Canadian HIV/AIDS Legal Network, 2006), pp. 41ff, online via www.aidslaw.ca/prisons; R. Jürgens, Interventions to address HIV in prisons: needle and syringe programmes and decontamination strategies, Evidence for Action Technical Papers (Geneva: WHO, UNODC & UNAIDS, 2007).

116 Government of the Kyrgyz Republic, Order "On regulations for pre-trial detention facilities (SIZO)", Order No. 229 (16 May 2008).

117 Jürgens, *Interventions to address HIV in prisons*, *supra*, p. 19-20.

118 See Section 6 below for more detail.

119 See Sections 4 and 6 below for more detail.

120 E.g., *Constitution of Turkmenistan* (26 September 2008), Article 5.

121 Ibid.

who use drugs and prisoners regularly experience human rights violations. (Notwithstanding the lack of individual formal complaints, some UN human rights treaty bodies have expressed concerns more generally about the HIV situation in some of the project countries and have highlighted the critical importance of expanding harm reduction services.[122])

As is evident from the country reviews, drug laws and policies in all the project countries are strict in punishing drug users. A wealth of evidence has been amassed demonstrating that such policies contribute to the marginalisation and stigmatisation of people who use drugs, undermining HIV prevention services that seek to reach them and inhibiting their access to care, treatment and support for HIV infection, drug dependence and other health concerns. As such, these policies run counter to states' human rights obligations and to good public health policy.[123] For example, people who use drugs are easy targets for arrest in enforcing strict laws on drug use and possession: in a study in Kazakhstan, 80% of injection drug users interviewed by Human Rights Watch stated that they had received a prison sentence at some point in life, and many had their fourth or fifth sentence on charges of drug possession or robbery.[124] According to the same report, once apprehended, detainees are subject to extortion, threats and physical ill-treatment; many may succumb to pressure from law enforcement agents to admit to false charges in response to coercive interrogation techniques or in exchange for drugs.

There are reports of systemic harassment and abuse of injecting drug users from police, torture of detainees in the law enforcement agencies. Based on interviews with drug users in Kazakhstan, Human Rights Watch reports cases of arbitrary arrest, verbal and physical mistreatment, physical abuse in some cases constituting torture, extortion, the planting of evidence on people who use drugs or sex workers, forced sex and coerced confessions.[125] Upon incarceration, many opioid-dependent prisoners are forced to undergo abrupt opioid withdrawal, which can impair capacity to make informed legal decisions and heighten vulnerability to succumb to police pressure.[126] Furthermore, policing practices and the fear of arrest and prosecution contribute to high-risk drug injection practices and discourage people who use drugs from seeking harm reduction services and HIV information and treatment.[127]

Concerns have also been raised by government health officials and harm reduction workers that a lack of understanding on the part of law enforcement officers, insufficient training and education on HIV and AIDS for police, and entrenched repressive attitudes towards drug users result in harassment and discrimination by police against those providing harm reduction services. For example, according to one government official in Kazakhstan, police can target people who use needle exchange sites for surveillance and arrest.[128] The same research found cases of outreach workers being detained for carrying boxes of empty syringes, and in two cities, several persons said that police conducted regular surveillance of pharmacies in order to identify drug users who buy disinfection material or syringes.[129] In the course of this project, national expert groups alluded to the concern that police practices could deter people who use drugs from seeking out health services. For example, the national expert group reported that in many cities in Kazakhstan people who use drugs are afraid to approach "trust points" (government-run facilities offering services including needle and syringe programmes) because being identified as a drug user may result in further targeting by police. One of the main reasons of not using services of the trust points was fear of being identified by the police.[130]

122 For example, in November 2006, the UN Committee on Economic, Social and Cultural Rights expressed concern at "the rapid spread of HIV in the state party, in particular among drug users, prisoners, [and] sex workers" and recommended that the government establish time-bound targets for extending the provisions of free…harm reduction services to all parts of the country: "Concluding Observations: Tajikistan," UN Doc. No. E/C.12/TJK/CO/1 (24 November 2006), para. 70.

123 For more discussion, see: J. Csete & J. Cohen, "Lethal Violation: Human Rights Abuses Faced by Injection Drug Users in the Era of HIV/AIDS," in Malinowska-Sempruch & Gallagher, *War on Drugs, HIV/AIDS and Human Rights*, *supra*, pp. 212-227; R. Elliott et al., "Harm Reduction, HIV/AIDS, and the Human Rights Challenge to Global Drug Control," *Health and Human Rights* 2005; 8(2): 104-138; and *At What Cost?: HIV and Human Rights Consequences of the War on Drugs*, *supra*.

124 Human Rights Watch, *Fanning the Flames*, *supra*, p. 21.

125 Ibid.

126 R.D. Bruce & R. Schleifer, "Ethical and human rights imperatives to ensure medication-assisted treatment for opioid dependence in prisons and pre-trial detention," *International Journal of Drug Policy* 2008; 19(2): 17-23.

127 Human Rights Watch, Fanning the Flames, supra, p. 18; see also J. Csete, Do Not Cross: Policing and HIV Risk Faced by People Who Use Drugs (Toronto: Canadian HIV/AIDS Legal Network, 2007), online via www.aidslaw.ca/drugpolicy.

128 Human Rights Watch, *Fanning the Flames*, pp. 32-33.

129 Ibid., p. 33.

130 See Kazakhstan country report.

The national expert groups also consistently reported that the effectiveness of current drug dependence treatment is low. The majority of patients return to drug use almost immediately following the course of treatment, for which they often have to pay, despite the fact that according to the law it is supposed to be free.[131]

Prison conditions remain harsh and life-threatening: prisons are generally overcrowded and unsanitary, and disease, particularly the spread of tuberculosis, is a serious problem. For example, government officials in Tajikistan reported that 36 prisoners died of tuberculosis or AIDS-related diseases in 2007.[132] According to the observations by the UN Committee Against Torture (CAT) on Tajikistan, there are numerous allegations concerning the widespread routine use of torture and ill-treatment by law enforcement and investigative personnel, particularly to extract confessions to be used in criminal proceedings.[133] There are reports of prisoners being denied or impeded in their access to legal counsel, family members and independent medical expertise. In Azerbaijan, Human Rights Watch has documented cases of torture, including through the use of electric shocks, severe beating, and threats of rape, as well as other incidents of torture in police stations throughout the country, as well as in prisons.[134] Corruption is widespread and prisoners must pay prison guards for privileges and sometimes even for health care.[135]

131 M. Khidirov & M. An, in K. Malinowska-Sempruch, Sarah Gallagher (eds.), *War on Drugs, HIV/AIDS and Human Rights* (Russian edition) (IDEA, 2004), p. 190. (Note: This article exists only in the Russian edition of this book.)

132 U.S. Department of State (Bureau of Democracy, Human Rights, and Labour), Country Reports on Human Rights Practices 2007: Tajikistan (11 March 2008), online: www.state.gov/g/drl/rls/hrrpt/2007/100621.htm.

133 UN Committee Against Torture, *Tajikistan: Conclusions and recommendations of the Committee against Torture*, 37th Sess., 6-24 November 2006.

134 Human Rights Watch, Briefing Paper: Azerbaijan and the European Neighbourhood Policy (15 June 2005), online: http://hrw.org/backgrounder/eca/azerbaijan0605.

135 Ibid.

3. ADMINISTRATIVE AND CRIMINAL LAW ISSUES

3.1 LAWS RELATED TO DRUGS: CURRENT SITUATION IN THE PROJECT COUNTRIES

In each of the six study countries, the law and its implementation reflect a repressive approach towards people who use drugs, and the national response to drugs accords a predominant role to law enforcement agencies, rather than health agencies. All six of the project countries have adopted similar national strategies and programmes against drug use and trafficking, with the dominant objectives of eliminating drug supply and use. However, in recent years the attitude has slowly begun to change: recent drug control programmes of some project countries (i.e. Kazakhstan and Kyrgyzstan) now include harm reduction measures.

Each country maintains administrative and criminal law prohibitions on drugs. Drug use *per se*, is formally prohibited in a number of countries, although it is not always penalized (e.g. with a penalty under the country's administrative or criminal code). Legislation in Azerbaijan provides for administrative liability for drug use. In Tajikistan and Turkmenistan, drug use without a doctor's prescription is prohibited according to the laws on drugs, but there is no penalty defined in administrative or criminal codes.[136] In Kazakhstan and Kyrgyzstan, drug use in public places leads to administrative penalty. Uzbekistan does not have either administrative or criminal liability for drug use, nor does the law on drugs state any prohibition on it.

Being intoxicated by narcotics or alcohol while committing an offence is an aggravating circumstance in the administrative and/or criminal laws of most of the project countries; this feature is inherited from the Soviet legal system. Azerbaijan and Tajikistan do not have such a provision, but it remains in the legislation of Turkmenistan, Uzbekistan, Kazakhstan and Kyrgyzstan.[137]

Possession of insignificant quantities of a narcotic substance in all project countries entails administrative or criminal charges. Each country developed Schedules defining minimum and maximum amounts of narcotic drugs and psychotropic substances the possession of which leads to administrative or (more often) criminal punishment (see Appendix 1). In most of the project countries quantities of narcotic substances are divided into "small," "large" and "extra large" quantities (or in the case of Uzbekistan, "small," "exceeding small" and "large" quantities; in the case of Tajikistan, the four categories of "small", "minor", "large" and "extra large").[138] The definitions of these different categories vary from country to country. The amounts for which possession leads to criminal liability are fairly small, with Uzbekistan and Kazakhstan having stricter limits and harsher penalties and Tajikistan taking a somewhat more liberal approach. Any quantity of heroin in Uzbekistan is classified as "exceeding small"; in Kazakhstan, any amount of heroin greater than 0.01 grams is defined as "large"; and in both countries possession of the above amounts of heroin leads to criminal liability. In Tajikistan, to illegally manufacture, produce, process, acquire, possess, transport or transfer narcotics in amounts less than "small" *without an intention to sell* is an administrative offence (e.g. less than 0.5g in the case of heroin) (see detailed description of amounts and penalties in individual country reports). Thus Uzbekistan and Kazakhstan's approaches have been extremely restrictive, whereas some other countries in the region have recognized that penalizing possession of such limited quantities is unnecessary and counterproductive, leading to some reforms to increase the quantities considered to be small enough so as not to attract at least criminal liability. In 2004, Tajikistan amended its *Criminal Code* by increasing significantly the minimum quantity of substance that would be required to trigger criminal charges for possession,[139] and currently has the most liberal approach to defining such quantities in the region.[140] Similarly, in 2007, a decree adopted in Kyrgyzstan increased the minimum quantity of substances that attracts criminal liability.

136 For example, in Tajikistan, neither the Criminal Code nor the Code on Administrative Responsibility makes it an offence merely to consume narcotic substances. However, Article 15 of the Law "On narcotic drugs, psychotropic substances, and precursors" states that consumption of narcotics and psychotropic substances without prescription is prohibited, although there is no penalty specified in law for breaching this section.

137 See individual country reports in Part II for specific references.

138 There is some variation in some countries' schedules. The schedules of controlled substances, which determine the scope and harshness of criminal or administrative liability for various drug-related offences, do not necessarily reflect the pharmacological dangers of particular substances: see comparative tables of controlled substances in Appendix 1.

139 K. Malinowska-Sempruch & S. Gallagher (eds.), *War on Drugs, HIV/AIDS and Human Rights* (IDEA, 2004).

140 See Appendix 1.

There is a distinction that legislators seek to draw between people who use drugs and people who deal drugs, by adopting in law the concepts of possession "for sale" and "not for sale". However, this difference is not always clear, since many people who use drugs sell small quantities of drugs to finance their own habit. In 2005, Azerbaijan introduced the notion of possession "for personal use".[141] In other countries, the law on drugs does not reflect the concept of possession for "personal use" or permissible possession of a quantity that is based on an "average single dose".

On paper, the criminal justice systems of all countries make allowance for alternatives to imprisonment in the case of at least some offences. According to the country expert groups, in Tajikistan and Kyrgyzstan practical efforts are being made to find alternative punishments in cases where the crime in question represents little danger to the public.

While needle and syringe programmes (NSPs) operate in all countries of the project with the exception of Turkmenistan, theoretically their implementation might contradict some provisions of the legislation related to drugs. In none of the project countries is possession of drug paraphernalia a criminal offence. However, the *Criminal Codes* of all project countries contain broadly formulated provisions on prohibition of and liability for "involvement" in the consumption of narcotics, "incitement" of drug use or organizing a site for drug consumption.

Provisions for involuntary testing for illicit drugs by law enforcement authorities are common to all six countries. Frequently, the laws provide that law enforcement authorities need only have a suspicion of drug use in order to have legal authority to stop a person and send him or her for drug testing.[142] The national expert group from Kyrgyzstan reports that random searches and detentions for drug testing use may be done.[143] In some cases, it is also an administrative offence for someone to avoid medical examination, including drug testing, and treatment if there is "adequate data" to indicate drug use.[144]

3.2 RATIONALE FOR REFORMING DRUG LAWS

Supply and demand reduction policies that are primarily or wholly dependent on the criminal law enforcement framework frequently have a negative impact on the health and the human rights of people who use drugs.[145] Such laws, policies and law enforcement practices can conflict with the goals of public health authorities and undermine the ability of these authorities to intervene and the efficacy of their interventions. Criminal law enforcement should not exacerbate existing social problems (through excessive criminal sanctions) or disrupt treatment and harm reduction services. Approaches to drug use that are based primarily on criminal prohibitions and penalties may increase, rather than decrease, the harms of drug use in a number of ways:

- In the absence of, or little access to, medically prescribed substitution medications, drug-dependent people turn to the underground market of illicit drugs, which are of unknown strength and composition, which may result in overdoses or other harms.
- Fear of being caught by police while consuming illicit drugs, as well as the high price of drugs, can push people to consume drugs in more efficient ways, such as by injection rather than, for example, by smoking — as a result, people engage in activities with greater risk for the transmission of HIV and other blood-borne infections.
- Because sterile injection equipment is not always available — and its availability may be impeded by drug paraphernalia laws and other criminal measures — people who use drugs may have to share needles and equipment, which further contributes to the spread of infection.
- Significant resources are spent on law enforcement, money that could instead be spent on the prevention of drug dependence and the expansion of treatment facilities for people with drug dependence. These are more effective ways to reduce demand for drugs, and avoid damaging health and human rights.

Strict law enforcement practices may impede access to essential health care services by people who use drugs.

> "[D]rug abuse problems cannot be solved simply by criminal justice initiatives. A punitive approach may drive people most in need of prevention and care services underground.
>
> – United Nations, *Preventing the Transmission of HIV among Drug Abusers* (2001)[146]

Criminal sanctions may make it difficult for health professionals to reach people who use drugs with essential health information and services; may make people who use drugs afraid to seek health or social services on their own initiative; may make service providers shy away from providing essential education on safer use of drugs or materials for the safer use of drugs (e.g., distributing sterile injection equipment), for fear of being seen to condone or promote drug use; and may foster prejudicial attitudes towards people who use drugs, directing action towards punishment of the "offender," rather than fostering understanding and assistance.

Governments sometimes claim that United Nations conventions on drug control require strict prohibitions on drugs and drug-related activities, and that tempering such prohibitions, including for the purpose of implementing various health measures to reduce the harms associated with drug use, would run counter to these conventions. However, this is inaccurate, and UN agencies have confirmed on multiple occasions that harm reduction measures do not contradict these treaties. (It should also be noted that these treaties were adopted at a time when it was not fully appreciated just how crucial a role injection drug use would play in fuelling the global HIV epidemic, and hence how critical it is to ensure that harm reduction measures be able to operate without being undermined by a strict criminalization and penalization of people who use drugs.)

The UN's three major drug control conventions are:

- the *Single Convention on Narcotic Drugs, 1961*;[147]
- the *Convention on Psychotropic Substances, 1971*;[148] and
- the *UN Convention Against Illicit Traffic in Narcotic Drugs and Psychotropic Substances, 1988*.[149]

These conventions can be interpreted so as to permit approaches that treat drug use as a health concern, including various harm reduction measures. The conventions allow states some flexibility in the extent to which they criminalize possession and use of controlled substances. There is increasing evidence that criminal prohibitions do not address — and can even worsen — some of the harms associated with problematic drug use. The widespread epidemic of HIV among people who use illegal drugs, particularly by injection, highlights the limits and problems of an approach that is strictly or overwhelmingly focused on criminalization and the imposition of harsh penalties. Therefore, it is important that states considering reform of domestic legislation be aware of the flexibility that is allowed under the international drug control conventions (see Box 6).

The UN drug control conventions may be correctly interpreted to support the implementation of such harm reduction measures as opioid substitution treatment, sterile syringe programmes and other. The UN Drug Control Programme (UNDCP), located within the UN Office on Drugs and Crime, issued a legal opinion to the International Narcotics Control Board (INCB) concluding that all of these measures can be seen as consistent with the three UN drug control conventions.[150]

141 *Law of Azerbaijan "On circulation of narcotic substances, psychotropic drugs and precursors*, Law No.959-IIQ (28 June 2005).

142 E.g., Article 16 of Tajikistan's *Law "On narcotic drugs, psychotropic substances and precursors"* and Article 18 of Tajikistan's *Law "On Narcological assistance"* ; Article 25 of Azerbaijan's *Law "On circulation of narcotic substances, psychotropic drugs and precursors"* ; Articles 50-51 of Turkmenistan's *Law "On narcotics, psychotropic substances, precursors and measures to counter their illegal circulation,".*

143 See the Kyrgyzstan country report in Part II.

144 E.g., Article 326 of Kazakhstan's *Code of Administrative Offences;* Resolution of the Cabinet of Ministers of Azerbaijan, No. 135 (7 August 2000).

145 This rationale is adapted from Legislating for Health and Human Rights: Model Law on Using Drugs and HIV/AIDS, Module 1: Criminal Law Issues (Canadian HIV/AIDS Legal Network, 2006), online at www.aidslaw.ca/modellaw.

146 United Nations, Preventing the Transmission of HIV Among Drug Abusers: A Position Paper of the United Nations System, Vienna, 26-27 February 2001, p. 9, online: http://www.unodc.un.or.th/factsheet/hiv.pdf.

147 *Single Convention on Narcotic Substances*, 520 UNTS 331, as amended by the *1972 Protocol amending the Single Convention on Narcotic Substances*, 976 UNTS 3.

148 *Convention on Psychotropic Substances*, 1971, 1019 UNTS 175.

149 *UN Convention Against Illicit Traffic in Narcotic Drugs and Psychotropic Substances*, 1988, UN Doc. E/CONF.82/15 (1988), 28 ILM 493 (1989).

150 UNDCP (Legal Affairs Section), Flexibility of treaty provisions as regards harm reduction approaches, Decision 74/10, UN Doc. E/INCB/2002/W.13/SS.5 (30 September 2002), available at: http://www.ungassondrugs.org/images/stories/un300902.pdf. The INCB assesses states' compliance with the treaties, but does not have the power to interpret or adjudicate them in any binding way.

Similarly, one important measure to reduce the harms associated with drugs, including HIV transmission, is to minimize the incarceration of people who use drugs. From the perspective of HIV prevention, the imprisonment of people on charges relating to their personal drug use is problematic. The notion that imprisoning people who use drugs decreases the spread of blood-borne infections, including HIV, is false. In many cases, prisoners have some access to drugs but little or no access to drug dependence treatment, including opioid substitution treatment, or sterile injecting equipment. As a result, policies that perpetuate the incarceration of people who use drugs exacerbate the spread of disease. The World Health Organization (WHO) has stated that prisons are high-risk environments for HIV transmission and other drug-related harms.[151] The European Union's Action Plan on Drugs (2005-2008) calls for member states to "further develop alternatives to imprisonment for drug abusers and drug services for people in prisons, with due regard to national legislation."[152] As noted below (see Box 6), the UN drug control treaties explicitly allow States Parties, including all of the project countries, to provide *alternatives* to conviction and incarceration for drug offences in their domestic law.[153]

In one form or another, alternative to prison sentence (for non-violent drug offences or offences committed by persons who use drugs) exist in many countries and in all countries of the European Union, although they vary greatly. In certain legal systems, the legislation requires the prosecution to stop a criminal proceeding if the accused consents to undergo treatment; in other systems, law enforcement agencies may force an offender to undergo treatment as part of sentence or in the place of imprisonment. In some legal systems, alternatives to criminal prosecution may be initiated by law enforcement agencies, in others by court agencies. Social and medical measures are a prevailing response to drug abuse (and often to the sale of drugs in small amounts) in all countries of the European Union. Treatment is suggested as an alternative to criminal prosecution in all countries. These measures are often applied towards people charged with actions related to drugs for personal use or possession of small quantities for sale, if committed by a person dependent on drugs. The fact is that most people using drugs may be involved in small scale trafficking to finance their drug dependence.[154]

"Drug treatment courts" represent one such alternative. In England, a court can order an offender to enter treatment and submit to drug testing for a specified period as an alternative to imprisonment. In Austria, Germany and Switzerland the approach of "therapy instead of punishment" is used, with the possibility of suspending prosecution or sentencing on the condition that the offender enter treatment. In Italy, prison sentences of no more than 4 years, or the last 4 years of a longer prison sentence, can be replaced by a period in judicially-supervised drug treatment. It requires an informed consent of the offender to enter treatment as an alternative to another sentence.[155]

However, a recent study in six European countries showed that the effectiveness of the so-called "quasi-compulsory treatment" — hybrid models of treatment and punishment for drug-dependent criminal offenders — is not proven.[156] Concerns have also been raised about whether some drug treatment courts may, in their operation, not respect human rights (e.g., the right to due process in a criminal or quasi-criminal proceeding by the state, the presumption of innocence); others question whether they are as effective as claimed and whether the resources spent on them would be better spent on improving access to voluntary treatment that is often inadequate. It is important for countries to divert people who use drugs from the criminal justice system, but careful consideration of how to design such diversion-into-treatment schemes is warranted.[157]

Furthermore, the 1988 Convention also states that in the case of the offence of possession, purchase or cultivation of drugs for personal consumption, a state may provide for "measures for the treatment, education, aftercare, rehabilitation, or social reintegration" of the offender, "either as an alternative to conviction or punishment, or in addition to conviction or punishment."[158]

151 WHO Europe, Status Paper on Prisons, Drugs and Harm Reduction (May 2005), online via http://www.euro.who.int.

152 European Council, EU Drugs Action Plan (2005-2008), 2005/C168/01, Objective 13.

153 *Single Convention on Narcotic Drugs*, 1961, UN, 520 UNTS 331, as amended by the 1972 Protocol, Article 36(2); *Convention on Psychotropic Substances*, 1971, UN, 1019 UNTS 175, Article 22; *Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances,* 1988, Article 3(4).

154 See more in Wolfgang Werdenich and Gabriele Waidner, Final Report on Quasi Compulsory Treatment – System Descriprions, European Commission, University of Kent, 2003, available via http://www.kent.ac.uk/eiss/projects/qcteurope/papers.html.

155 A. Stevens et al, "The Relationships between Legal Status, Perceived Pressure and Motivation in Treatment for Drug Dependence: Results from a European Study of Quasi-Compulsory Treatment," European Addiction Research 2006; 12:197-209.

156 A. Stevens, The treatment/punishment hybrid: selection and experimentation, Paper presented at the 4th Annual Conference of the European Society of Criminology, Amsterdam, August 2004, available via http://www.kent.ac.uk/eiss/projects/qcteurope/papers.html.

157 For some further discussion, and possible legislative options, see Legislating for Health and Human Rights: Model Law on Drug Use and HIV/AIDS, Module 1: Criminal law issues, pp. 23-30, online via www.aidslaw.ca/modellaw.

Box 6: Flexibility under the United Nations conventions on drugs

Both the 1961 *Single Convention* and the 1971 *Convention on Psychotropic Substances* allow for the production, distribution or possession of controlled substances for "medical and scientific purposes." Furthermore, both of these conventions also require states to "take all practicable measures" to provide treatment, education, rehabilitation and social reintegration of people who use drugs, and note that these measures may be provided "as an alternative to conviction or punishment."[159] States determine how they will interpret and implement these provisions in their domestic law.

The 1988 *UN Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances* is often incorrectly interpreted as requiring the absolute criminalisation of possession of narcotic substances for any purposes and the imposition of prison sentences for possession for personal consumption. However, the treaty says only that states which ratify the treaty must make it a criminal offence under domestic law to possess, purchase or cultivate drugs for personal consumption "contrary to the provisions of the 1961 Convention, the 1961 Convention as amended or the 1971 Convention." Thus, the flexibility found in the two earlier conventions is preserved. As noted above, those Conventions include a number of provisions that make it legally permissible to remove, at least to some degree, the criminalization of people who use or possess drugs — if, for example, decriminalization is in pursuit of "medical or scientific purposes" or forms part of practicable measures to provide care, treatment or support to people who use drugs. It is incorrect to interpret the 1988 Convention as requiring the complete criminalization, without exception, of possession of a drug for the purposes of personal consumption.

3.3 RECOMMENDATIONS FOR REFORMING DRUG LAWS AND POLICIES

In the *International Guidelines* on *HIV/AIDS and Human Rights*, UNAIDS and the Office of the UN High Commissioner for Human Rights have recommended that "criminal law should not be an impediment to measures taken by States to reduce the risk of HIV transmission among injecting drug users and to provide HIV-related care and treatment for users".[160] The Guidelines thus recommend that states should "review and reform criminal laws and correctional systems to ensure that they are consistent with international human rights obligations and are not used unfairly in the context of HIV/AIDS and against vulnerable population groups".[161] To this end, below we identify some key reforms that are needed in some or all of the six countries that participated in this project. (The individual country reports that accompany this integrated report provide specific, detailed recommendations for reforms to legislation and policies for each of the countries that participated in the project.)

Recommendation 1: Decriminalise and/or depenalize the possession of narcotic substances for personal use

The negative consequences for individual and public health, and for human rights, of the ongoing prosecution and punishment of people for drug possession have been outlined above. It has also been clarified that countries enjoy some flexibility under the UN drug control conventions to adopt approaches that are less based on prohibition and punishment and instead reflect the reality that drug use and drug dependence are ultimately health issues that should be treated as such. Given the nature of drug dependence as a chronic, relapsing condition, existing criminal and administrative provisions largely have the effect of penalizing people with the health condition of drug dependence. Therefore, in each of the countries that participated in the project, the national expert group concluded that it was necessary to "humanize" existing legislation by *decriminalizing* the possession of drugs for personal use, and even in some cases removing administrative penalties for such possession (*depenalization*). To this end, legislation on drugs

158 1988 Convention, Article 3(4).

159 1961 Convention, Articles 38, 36(2); 1971 Convention, Articles 20, 22.

160 HIV/AIDS and Human Rights: International Guidelines, Guideline 5, para. 29(d) (Geneva: Office of the UN High Commissioner on Human Rights and Joint UN Programme on HIV/AIDS, 1998), online via http://www2.ohchr.org/english/issues/hiv/index.htm.

161 *HIV/AIDS and Human Rights: International Guidelines*, Guideline 4, ibid.

should establish criteria for determining when drugs are possessed for "personal use" and hence do not attract criminal and/or administrative penalties. It should be noted that in some former Soviet countries, government authorities have allegedly taken some such steps, but often the allowed quantities of drugs for "personal use"(or "without intention to sell")[162] have been set so low that in reality possession of even a very small quantity exceeded the allowed amount. In decriminalizing and depenalizing possession of drugs for personal use, the standards set by the law should reflect the reality of the quantities commonly used for personal use, or else such measures are illusory and of little practical benefit.

In order to remove criminal and/or administrative penalties for possession of drugs for personal use, countries should take the following steps, where relevant to the particular state of their domestic law:

1.1 Raise the threshold of the minimum quantities of drugs that trigger criminal liability for possession: In several of the project countries, the national expert groups concluded that the minimum quantities of drugs that trigger criminal liability for possession are set too low in the law, meaning that possession of drugs for personal use (i.e. not for sale) remains prohibited and penalized *de facto* as a crime. Countries should change their domestic laws to increase the quantity of drugs that a person is allowed to possess for personal use without facing criminal charges, so as to reflect the reality of how people use drugs.

1.2 Eliminate criminal and administrative liability for possession of small amounts of drugs not for the purpose of sale: In Azerbaijan, Kazakhstan, and Kyrgyzstan, the national expert groups recommended the further decriminalization and depenalization of the possession of small amounts of controlled substances "without intention to sell," meaning that such possession would also not amount to criminal or administrative offence and would avoid penalty. This recommendation is equally relevant to the other project countries.

1.3 Eliminate administrative liability for mere drug use: Several project countries prohibit drug use in their drug laws; some impose administrative liability for mere drug use (Azerbaijan), for appearing in public in the condition of intoxication (Kyrgyzstan) or drug use in public places (Kazakhstan and Kyrgyzstan). It is recommended that such provisions be repealed.

1.4 Ensure that the law considers the quantity of the prohibited substance alone, without additives: In many cases, a prohibited drug may be transported or sold mixed with other substances (e.g. fillers such as flour). However, as a matter of fairness, in measuring the quantity of a drug for purposes of determining whether it should be considered to attract criminal or administrative penalty, and if so what penalty, it is important to consider only the quantity of the prohibited substance itself, rather than including in the measurement any other substances. This is of particular relevance to a country such as Kyrgyzstan, where the measurement of the quantity of a drug in someone's possession includes such fillers; reform is needed to the government decree to clarify that it is only the quantity of the substance itself that will be considered.[163]

Recommendation 2: Ensure criminal and administrative laws do not impede the effective operation of programmes aimed at protecting the health of people who use drugs and public health

The review of law and policy in the project countries revealed a number of aspects of existing criminal and/or administrative laws that could, in various ways, operate to undermine the effectiveness of harm reduction programmes in protecting and promoting the health of individuals who use drugs and, therefore, public health more broadly. Simple measures could be taken easily, including by way of legislative amendment, to make explicit that such programmes are not contrary to criminal or administrative laws related to drugs.

1.1 Repeal prohibitions on possession of drug paraphernalia: In at least one project country (Turkmenistan), the law prohibits the possession of "instruments and equipment" used for the illegal use of controlled substances.[164] If and when these provisions are applied by law enforcement to confiscate or destroy syringes and other equipment for safer drug use, this has an obvious negative effect on HIV prevention efforts. It encourages people to avoid possessing injection equipment, such as the sterile equipment available from needle and syringe programmes or purchased from pharmacies; this leads to sharing non-sterile equipment. Successful HIV prevention among people who inject drugs requires easy access to clean injection equipment, and any law that exposes people to criminal or administrative prosecution for possessing such equipment runs counter to public health efforts.

1.2 Ensure no liability for possessing residual amounts of drugs in used injection equipment or other items used for consumption of drugs: In some cases, the law could be interpreted or applied to prosecute someone for possessing residual amounts of narcotics in used syringes or on other equipment used to ingest drugs.[165] Such an interpretation and application of the law is counterproductive from a public health perspective. It creates an incentive for someone to dispose quickly of a syringe or other equipment after it has been used, rather than dispose of it safely, such as returning it to a needle and syringe programme where new, sterile equipment can also be obtained. It therefore contributes to the disposal of used syringes in public places and encourages subsequent sharing of injection equipment with others. It also conceivably exposes staff and volunteers of harm reduction services such as needle and syringe programmes to potential liability for possession of used drug paraphernalia that is returned to their facility or that they collect through peer outreach efforts. Countries with such provisions in their law should repeal them so as to eliminate legal liability for possession of residual quantities of drugs. In addition, it should be made explicit, including ideally through legislative amendments, that staff and volunteers delivering harm reduction programmes are not exposed to legal liability for distributing or possessing drug paraphernalia.[166]

1.3 Ensure harm reduction programmes are not prosecuted for "incitement of drug use", drug "propaganda" or operating a "site for drug consumption": All project countries have provisions in their *Criminal Codes* that prohibit "incitement" or "inducement" to drug use[167], or "involvement in drug use."[168] Some countries also have provisions that prohibit "propaganda" for drug use or the "promotion and advertisement"[169] of prohibited drugs, and usually the legislation provides no or very wide definition of such terms. Similarly, some countries make it a criminal offence to "organize a site for drug consumption".[170] While it is not warranted, and should be actively discouraged by government authorities and law-makers, there is the unfortunate potential that such provisions could be interpreted and applied by law enforcement personnel in ways that interfere with the effective operation of health services that seek to reach people who use drugs, if those authorities incorrectly consider such programmes as encouraging the use of illegal drugs. In order to ensure the staff and volunteers of harm reduction programmes are not subject to the risk of criminal prosecution for providing these health services, it is recommended that legislative provisions be adopted that make explicit that any such criminal prohibitions do not apply to such programmes.[171]

162 The concept of "personal use" exists only in the legislation of Azerbaijan. In the other project countries drug offences are divided into those committed "with intention to sell" and those committed "without intention to sell", which distinction allegedly serves the same purpose of distinguishing offences for personal use and drug trafficking.

163 See Kyrgyzstan country report, Recommendation 4.

164 E.g., Article 45 of Turkmenistan's *Law "On Narcotics, Psychotropic Substances, Precursors, and Measures to Counteract their Illicit Trafficking"* (9 October 2004).

165 E.g., Article 42.1 of Tajikistan's *Code of Administrative Responsibility*; Government of Kyrgyz Republic, Decree No. 543 "On narcotic drugs, psychotropic substances and precursors, controlled in the Republic of Kyrgyzstan" (9 November 2007); Article 43(1) of Turkmenistan's *Administrative Offences Code*; Article 234 of Azerbaijan's *Criminal Code*.

166 For sample wording of legislative provisions that could achieve this, see Legislating for Health and Human Rights: Model Law on Drug Use and HIV/AIDS, Module 3: Sterile syring programs (Canadian HIV/AIDS Legal Network, 2006), online via www.aidslaw.ca/modellaw.

167 E.g., see the *Criminal Codes* of Turkmenistan (Article 296), Kyrgyzstan (Article 249) and Kazakhstan (Article 261), Azerbaijan (Article 236).

168 E.g., Article 203 of Tajikistan's *Criminal Code*.

169 E.g., Article 47 of Turkmenistan's *Law "On Narcotic drugs, psychotropic substances, precursors, and measures to counter their illegal circulation."*

170 E.g., Article 205 of Tajikistan's *Criminal Code*.

171 Examples of specific phrasing can be found in the relevant country reports (in Part II), or in Legislating for Health and Human Rights: Model Law on Drug Use and HIV/AIDS, Module 3: Sterile syring programs (Canadian HIV/AIDS Legal Network, 2006), online via www.aidslaw.ca/modellaw.

Recommendation 3: Create alternatives to imprisonment for drug-related offences and people who use drugs

Project countries should take a number of steps to reduce the incarceration of people who use and are dependent on drugs, and hence reduce both risky drug use and the number of people with HIV in prisons, and to ensure that administrative penalties do not interfere with access to health services (e.g., harm reduction programmes):

1.1 Create alternatives to incarceration: It is recommended that the project countries enact and implement legislative provisions providing for alternatives to incarceration for those convicted of non-violent drug-related criminal offences (which should include offences linked in some way to a person's drug use). This may include such measures as the following: fines; temporary deprivation of the right to engage into certain activities (the period should be specified for every case and reviewed by the court on a regular basis); a requirement to attend education sessions aimed at preventing drug use; and participation in treatment in case of drug dependence.[172]

1.2 Limit the use of pre-trial detention: In the interests of avoiding the unnecessary incarceration of people who use drugs, it is also recommended that countries limit the use of pre-trial detention for persons charged with commission of non-violent offences (including those related to drugs).

1.3 Repeal administrative punishments limiting access to health services: Finally, it is recommended that countries conduct a similar review of sanctions in the administrative law and should adopt measures to ensure that administrative punishments such as "arrest" are not applied inflexibly in ways that limit access for people who use drugs, including those who are drug-dependent, to needed health services.[173]

Recommendation 4: Eliminate discriminatory treatment of people who use drugs by removing intoxication as an aggravating factor for criminal liability and sentencing

Under the law in several of the project countries (Kazakhstan, Kyrgyzstan, Uzbekistan and Turkmenistan), being intoxicated by drugs or alcohol while committing an offence is a factor that aggravates liability and/or the sentence imposed.[174] However, whether or not a person is intoxicated does not affect the gravity of the harm of his or her crime, so it should not be considered as making the crime more serious. Rather, such provisions effectively discriminate against people accused of crimes based on their health status (i.e., dependence of drugs or alcohol), imposing harsher penalties for a given crime on people with this health condition. Such provisions should be repealed by the countries that currently have them in their *Criminal Codes*.

Recommendation 5: Eliminate coerced referral to drug testing by law enforcement authorities

As noted above, the law in all project countries allows law enforcement authorities to refer people involuntarily to drug testing, even based simply on a suspicion of drug use. Such wide provisions on coercive drug testing, vesting extensive powers in law enforcement bodies, represent an inefficient use of limited resources and are also an unjustified intrusion on human rights. For example, subjecting someone who has not committed any offence to involuntary drug testing violates the rights to liberty, security of the person and privacy, as well as the right to be free from non-consensual medical intervention; if test results are also used against the person in any sort of prosecution, it would also violate the right against self-incrimination.[175] The only basis on which it might be justifiable for the state to infringe such human rights would be to intervene to prevent a serious risk of harm to oneself or to others; mere use of alcohol or drugs does not, by itself, establish this.

Involuntary drug testing is inconsistent with the recommendations of international organizations, such as the *International Guidelines on HIV/AIDS and Human Rights*, and in particular the recommendation that "criminal law should not be an impediment to measures taken by States to reduce the risk of HIV transmission among injecting drug users and to provide HIV-related care and treatment for injecting drug users."[176] Involuntary drug testing may encourage people who use drugs to go underground, discourage them from using medical services (including seeking medical assistance in cases of overdose) and thereby contributes to the further spread of HIV and to other harms. The national expert groups have concluded that it is advisable to forgo such involuntary drug testing.[177] It is recommended that project countries repeal the provisions in their current laws that authorize involuntary drug testing by law enforcement authorities, unless a person presents a serious risk to him/herself or others.

3.4 Recommendations regarding other HIV-related issues of concern

This project's focus was specifically on the legal and policy barriers to effective prevention and treatment of HIV infection among persons using drugs and people in prisons. However, the assessment by the national expert groups, UNODC and the project's technical advisors identified a number of other provisions in some project countries' criminal and administrative laws that hinder HIV prevention and treatment among vulnerable groups. In particular, most of the project countries continue to criminalise marginalized groups such as sex workers and men who have sex with men; they also tend to have measures specifically singling out HIV transmission and exposure for criminal prosecution. As discussed further below, these approaches run contrary to international human rights standards and/or international policy recommendations. These concerns are noted here in brief, and in the relevant country reports (in Part II), as are some recommendations for reform.

Recommendation 6: Repeal criminal laws prohibiting sex between consenting adults of the same sex

The criminalization of sex between men was inherited from the legal system of the Soviet Union, but has been abolished in the project countries except Uzbekistan and Turkmenistan, where this reform is still needed.[178] Although the provisions criminalizing sex between adult men appears to be rarely used (e.g., in recent years there was only one conviction under this article in Uzbekistan), the existence of this provision in a country's *Criminal Code* contradicts international human rights standards and is counter-productive for public health. The UN Human Rights Committee has ruled that laws criminalising sex between adult men violates the right to private life under Article 17 of the *International Covenant on Civil and Political Rights* (which has been ratified by all of the project countries):

> ...the criminalization of homosexual practices cannot be considered a reasonable means or proportionate measure to achieve the aim of preventing the spread of HIV/AIDS... [B]y driving underground many of the people at risk of infection ....[it] would appear to run counter to the implementation of effective education programmes in respect of the HIV/AIDS prevention.[179]

In addition, the criminalization of men who have sex with men (MSM) violates the human rights recog-

172 For example, the national expert group of Kyrgyzstan recommended legislation to establish a Commission to deal with cases connected with illegal manufacturing, acquisition, possession, transportation or transfer of narcotics or psychotropic substances in a small quantity and without intention to sell, which Commission could impose punishments in the form of warnings, fines, restrictions in movement or visiting certain places, and referral to demand reduction programs: see Kyrgyzstan country report in Part II.

173 In this context, the term "arrest" is generally used in the administrative codes of some countries to denote a period of strict isolation, although not necessarily in a prison or similar facility, but perhaps in the person's own residence (i.e., "house arrest").

174 Article 54 of Kazakhstan's *Criminal Code*; Article 55 of the Kyrgyz Republic's *Criminal Code*; Article 56 of Uzbekistan's *Criminal Code*; Article 25 of Turkmenistan's *Criminal Code*. Such provisions do not exist in the law of either Azerbaijan or Tajikistan. In Kazakhstan, the law provides that courts have the discretion to refrain from treating this as an aggravating factor, depending on the nature of the offence.

175 *International Covenant on Civil and Political Rights*, 999 U.N.T.S. 171 (1966), Articles 7, 9, 14 and 17.

176 *International Guidelines*, Guideline 4, para. 21(d).

177 For example, in Kyrgyzstan, the national expert group recommended that the Ministry of the Internal Affairs adopt an order prohibiting unwarranted searches or detention based on suspicion of drug use, including based on the presence of drug-injection marks: see Kyrgyzstan country report in Part II.

178 Article 135 of the *Criminal Code* of Turkmenistan, and Article 120 of the *Criminal Code* of Uzbekistan.

179 UN Human Rights Committee, *Nicholas Toonen v. Australia*, Communication No. 488/1992, UN Doc. CCPR/C/50/D/488/1992 (31 March 1994), para. 8.5.

nized in the Constitutions of both Uzbekistan and Turkmenistan, specifically the right to privacy, the right to freedom and personal inviolability and the right to protection from infringement of honour and dignity.[180] As recommended in the *International Guidelines on HIV/AIDS and Human Rights*, such provisions should be repealed by Uzbekistan and Turkmenistan.[181]

Recommendation 7: Reform criminal and administrative laws to decriminalize and depenalize sex workers

Laws that make it an administrative or criminal offence to engage in sex work do not prevent sex work, but they do lead to human rights abuses against sex workers and hinder HIV prevention and treatment efforts for this vulnerable population. Such laws drive sex workers underground or to marginal situations, making it harder for them to reach and be reached by health services as well as exposing them to a greater risk of violence, extortion and abuse by clients and by police. These laws need to be reformed so as to protect sex workers' rights and their ability to protect their health and hence that of their clients. The *International Guidelines on HIV/AIDS and Human Rights* recommend that "criminal law should not impede provision of HIV prevention and care services to sex workers and their clients," and that "adult sex work that involves no victimization" should be decriminalized.[182]

Five of the project countries — Azerbaijan, Kazakhstan, Tajikistan, Turkmenistan and Uzbekistan — need to repeal administrative law provisions that penalize sex workers (as well as provisions imposing criminal liability for a repeated offence after an administrative penalty has been imposed). (Specific details of the applicable legislation, and specific recommendations, for each country are in the individual country reports in Part II.)

Kyrgyzstan is the only one of the six project countries in which there is no administrative liability for engaging in sex work.
However, according to the assessment by the national expert group, sex workers in Kyrgyzstan are often harassed by police (prosecuted for offences of "debauchery" and "violation of public order") and referred for compulsory STI testing. Therefore, in all countries, Kyrgyzstan included, health and law enforcement authorities should implement human rights training, including training in the area of human rights (including refraining from such involuntary HIV and other STIs testing). Human rights protecting bodies need to be trained to respond appropriately to abuses by law enforcement against sex workers.

Recommendation 8: Abolish HIV/STI-specific criminal offences and limit the scope of such laws

All six of the project countries specifically make it a crime to expose someone to HIV or transmit HIV, with *Criminal Code* provisions that are quite open-ended. Yet according to international policy recommendations, national legislation should not include criminal offences that single out HIV transmission or exposure; such an approach contributes to HIV-related stigma by singling out people living with HIV. Rather, crimes of general application should be used to handle these exceptional cases. The *International Guidelines on HIV/AIDS and Human Rights* recommend that any application of such general criminal offences "should ensure that the elements of foreseeability, intent, causality and consent are clearly and legally established to support a guilty verdict and/or harsher penalties."[183] Furthermore, UNAIDS has recommended that the application of the criminal law should be limited to those cases where someone acts with malicious intent to transmit HIV and does in fact transmit the virus.[184]

Many of the project countries also apply criminal liability even more broadly. In some project countries, there is criminal or administrative liability not only for HIV exposure and transmission, but also for exposure and transmission of other sexually transmitted infections (STIs). In Uzbekistan, it is also a crime to conceal the source of one's HIV infection. In some countries (e.g., Kazakhstan), it is an administrative offence for someone to avoid medical examination for certain diseases, including HIV (in addition to criminal and administrative liability for avoiding drug testing).[185] In general, these sorts of provisions should be repealed or at least narrowed. Specific recommendations to this effect for each country are found in each of the relevant country reports (Part II).

180 Constitution of Turkmenistan, Articles 25 (privacy) and 43 (judicuial protection of honour and dignity); Constitution of Uzbekistan, Articles 25 (right to freedom and personal inviolability) and 27 (protection of privacy honour and dignity).

181 *International Guidelines*, para. 21(b).

182 Ibid., para. 21(c).

183 Ibid., para. 21(a).

184 UNAIDS, *Policy Brief: Criminalization of HIV Transmission* (2008).

185 *Code of Administrative Offences* of Kazakstan, Articles 326-327.

4. HEALTH CARE SYSTEMS AND SERVICES

4.1 HEALTH CARE IN THE PROJECT COUNTRIES

4.1.1 HEALTH CARE SYSTEMS: STRUCTURE, ACCESS TO SERVICES AND PATIENTS' RIGHTS

The constitutions of all project countries guarantee their citizens access to public health care. The underlying concept and structure of the current public health care in these countries is still based on the Soviet model. However, unlike the totally free-of-charge Soviet health care, public health services of the six countries are using financing schemes that combine various sources of funding: certain services are provided free of charge (usually basic emergency and primary health care and some specialist services), while some other services are either wholly or partly paid for by patients.

Health care consists of primary health care (provided in policlinics and their analogues); secondary health care at the level of rural districts, cities and provinces (general hospitals); and tertiary health care or specialist services (i.e. cardiology, narcology, infectious diseases, mental health, STI, tuberculosis and other clinics, AIDS Centres) that serve as lead clinical and methodological centres at provincial and national levels.

One prominent feature of the Soviet health care was a system of dispensaries (health care facilities) for preventing and treating prevalent health conditions, especially those that are chronic, difficult to treat and frequently recurring , such as tuberculosis, psychiatric disorders, alcohol and drug dependence, cancer and STIs. There was a system of dispensaries at the municipal, provincial and national levels, with a relevant hierarchy of accountability. National dispensaries (now often called centres) usually have served also as research centres and been responsible for submitting statistics and situation assessments in their field of services to Ministries of Health, as well as developing standards/protocols of service provision and other recommendations for improving the effectiveness of public health interventions. The original intent of this system was to make specialist services easily accessible for those with these chronic diseases, which often required long-term and expensive treatment (thus the lists of "socially significant diseases" described below, which prescribe financial and social benefits for the patients along with certain obligations).

Given the over-representation of socially disadvantaged populations among patients with these diseases, the financial burden of care for patients and their families was alleviated by ensuring no-cost treatment, free provision of prescription drugs and the opportunity of aftercare. Social support to patients was provided by the so-called patronage nurses conducting home visits, who would become familiar with the social and medical factors affecting a patient's health and help to obtain basic social assistance (i.e. from the state welfare bodies). The system was meant to mitigate the social consequences of these health problems (e.g., destitution because of illness), thus contributing to the overall health and well-being of the population. The system of specialized dispensaries was established in the 1920-30s and for the next 50 years was quite effective. Over time, some types of dispensaries were closed down, as successful treatment and improved social conditions reduced the number of patients needing that particular type of care (e.g. dispensaries for trachoma treatment). For many other health conditions, treatment outcomes were not so successful, and in many cases rather frustrating (e.g. for alcohol and drug dependence). Moreover, quite often patients attending tuberculosis, STI and narcological dispensaries (and, recently, AIDS centres) were the same socially disadvantaged people. The state response to this situation was to focus on measures aimed at isolating patients from "harmful social environments" and controlling their behaviour (e.g. strict requirements to visit dispensaries at certain times for "maintenance treatment", restriction of certain activities and occupations, coercive treatment in the event of avoiding voluntary treatment and behaving in a disorderly fashion). While the approach was originally intended to cure and provide social protection to people with serious chronic health conditions, it has transmuted into a repressive system with medical establishments and their personnel playing an uncharacteristic role of controllers rather than health care providers. In addition, this (mostly in-patient) system has been very expensive, requiring vast monetary and human resources which could not be provided in full.

In the past decade, new evidence-based methods of treatment of tuberculosis (e.g., directly-observed therapy, short-course – or DOTS), STI (syndrome approach) and drug dependence (e.g. OST) have been gradually introduced in the health care systems of some of the project countries. However, despite their proven effectiveness and relative inexpensiveness, these methods are still not easily available, and the project countries still maintain the old system of predominantly inpatient treatment of tuberculosis, STIs and drug dependence, with all the attributes of control and restriction just noted.

Accessibility of health care services

In each of the project countries, emergency health care is provided free of charge to everyone, including people without certificate of domicile, migrants and foreigners. The provision of primary health care is based on territorial divisions, meaning that a certain medical facility is responsible for the provision of basic services, mostly free-of-charge, to people residing in a certain administrative territory (i.e. a city district or rural district). To receive health services, a person should provide a certificate of domicile proving permanent residence in the facility's catchment area. People temporarily residing in a different residential area must register as temporary residents (i.e. obtain a temporary certificate of domicile). If a person requires health care outside of his/her residential area, health services are provided for a fee.
The exception to this scheme is Kyrgyzstan, where health care services and medications are provided free of charge to the patient only in the case of emergency care; in other cases, health care is provided on the basis of medical insurance, and specific diseases, such as drug dependence treatment, require a co-payment by the patient.

In four of the project countries (Azerbaijan, Kazakhstan, Turkmenistan and Uzbekistan), legislation and government regulations or orders classify some diseases as being of particular concern ("socially significant diseases" and "socially dangerous diseases").[186] The lists of such diseases are adopted and renewed by the relevant government body on a regular basis. In the project countries with such lists, HIV infection and AIDS are included in both categories, along with viral hepatitis B and C, tuberculosis and sexually transmitted diseases. Mental and behavioural disorders (including drug dependence) are generally incorporated in one or both lists. Such classification usually means both benefits for those with the disease (e.g., free treatment) and restrictions on rights (e.g. being subjected to coercive treatment).

In Azerbaijan, legislation guarantees free treatment of unlimited duration for "socially significant diseases" and "socially dangerous diseases"; both categories include HIV infection, drug dependence, tuberculosis, viral hepatitis and others.[187] However, according to the national expert group, the reality of service accessibility is different because of limited funding and the poor quality of free health services. The experts report that, while a patient seeking medical assistance at a health facility may be admitted to a hospital without undue delay, the patient may have to provide his or her own meals, medications and bed linen. The *Law "On private medical practice"* excludes the treatment of "socially dangerous diseases" from the list of services that may be rendered by private health care institutions (and this includes OST as treatment for drug dependence).[188]

In Kazakhstan, the guaranteed scope of medical assistance for citizens covered by the state includes primary medical care, accident and emergency medical care, secondary health care upon referral by primary health care specialists, and medical care for people with "socially significant diseases" and "diseases posing a threat to others."[189] Drug dependence is classified as a "socially significant disease," while HIV infection, viral hepatitis, plague and tuberculosis are considered "diseases posing a threat to others".[190] The national HIV law guarantees free medical assistance (including ARV medications) to persons with HIV infection and with AIDS within the guaranteed scope of free medical assistance.[191] Treatment for drug

186 In Kyrgyzstan, Article 30 of the *Law "On protection of public health"* [об охране здоровья граждан], Law No. 6 (9 January 2005) refers to "socially significant diseases" and "diseases dangerous to others", but according to national experts there are no definitions and no lists of these diseases. There are no lists of these diseases in Tajikistan.

187 E.g., Azerbaijan's *Law "On prevention of HIV and AIDS"*, Law No. 282-IQD (25 April 1997), Articles 3 and 4. Note that HIV infection, tuberculosis and drug dependence are also both classified as "socially dangerous diseases": *Law on public health care* [Закон об охране здоровья населения], Law No. 360-IQ (26 June 1997); the list of diseases is set out in a decision adopted by the Cabinet of Ministers, Resolution No.5 (12 January 1990).

188 *Law of Azerbaijan on private medical practice* [О частной медицинской деятельности], Law No. 789-IГ (30 December 1999).

189 *Law* of Kazakhstan *"On Health and Disease Control"*, No. 361-II (4 December 2002), as subsequently amended by Law No. 13-III (20 December 2004).

190 Government of Kazakhstan, "On Approval of the List of Social Diseases and Diseases Posing Threat to Others", Resolution No. 467 (30 March 2000).

191 Law "On Prevention and Treatment of HIV Infection and AIDS", Law No. 176-XIII (5 October 1994), Article 2-4.

dependence is also provided free of charge within the scope of the guaranteed free medical assistance, as drug dependence is deemed to be a "socially significant disease".[192] Fee-based drug dependence treatment is also easily available. However, the national expert group notes that the system of providing guaranteed care based on one's registered area of residence creates barriers to access to health care for homeless people and people without personal identification (ID). Stateless persons and foreigners are only entitled, without charge, to emergency medical care.[193]

A similar system is in place in Tajikistan**,** where all health services, including treatment for drug dependence and HIV infection, are provided free-of-charge, in accordance with the constitutional provision stating that citizens are entitled to free use of the system of health care facilities.[194]

The government of Kyrgyzstan annually adopts a "Programme of State Guarantees" that determines specific population categories entitled to certain free primary health care services. According to the Programme, emergency inpatient care, including resuscitation, is free. The national HIV law provides for priority access to all types of primary care facilities and provision of medication for people living with HIV (PLHIV) in accordance with the Programme of State Guarantees.[195] Under Kyrgyz law, treatment at a drug dependence clinic is only partially covered by the state, requiring a co-payment by the patient.[196]

Turkmenistan guarantees free use of the network of official public health facilities by its citizens, foreign nationals, stateless persons and refugees. Access to primary and emergency health care is provided based on the proof of individual's place of residence. According to the expert group, for those who are unemployed or without a specific residence, provision of free health services is carried out in accordance with the general practice in the place where the application was made. Legally, migrants and refugees have access to treatment equal to that of citizens of Turkmenistan. Turkmenistan's national HIV law ensures free treatment of persons requiring ARV therapy,[197] however, according to official reports ARV therapy is currently not available in Turkmenistan. (In 2008 the government reported only 2 officially registered HIV infection cases). The official list of infectious diseases "representing a danger to other people" includes HIV infection alongside such highly contagious communicable diseases as plague, cholera and hemorrhagic fevers.[198]

In Uzbekistan, the government has established a guaranteed scope of health care services provided for free at state health care facilities.[199] All health services outside the guaranteed scope of services are paid for privately by patients. Access to health services for stateless persons legally living in Uzbekistan is equal to that of Uzbek citizens; access to health services for certain foreign nationals is established pursuant to treaties with other states.[200] Free health services are guaranteed by the government to all patients with "socially significant diseases", the list of which includes tuberculosis, sexually transmitted infections (STIs), HIV infection, malignant growths, leprosy and "mental health disorders" (including drug dependence).[201] People with "socially significant diseases" receive medical assistance and free medication at outpatient facilities, and treatment in inpatient facilities. Treatment for drug dependence is guaranteed by the state, whose specialized medical facilities provide such treatment for free. However, if desired, patients may

192 Government of Kazakhstan, "On Approving a List of Guaranteed Scope of Health Services for 2006-2007", Resolution No. 1296 (28 December 2005), item 20.

193 *Law "On Public Health Care"*, Law No. 430-2 (4 June 2003).

194 *Constitution of Tajikistan*, Article 38.

195 *Law "On HIV/AIDS in the Kyrgyz Republic"*, Law No. 149 (13 August 2005), Article 6.

196 "Regulation on co-payment for medical services provided by public health system operating in the system of unified payment", Government Government Resolution No. 363 (24 August 2007) [Положение о сооплате за медицинские услуги, предоставляемые организациями здравоохранения, работающими в системе Единого плательщика].

197 Moreover, according to Turkmenistan's Law "On HIV/AIDS", people with HIV on outpatient treatment are provided with free drugs. PLWH are reimbursed travel expenses to and from the health facility within the country by a health facility at the place of permanent residence. Parents (or caretakers) with HIV positive children are entitled to stay with them at an inpatient facility and receive a temporary disability [sick leave] allowance. For one of the parents (or caretakers), the period of care for an HIV-positive child is carried over as tenure. Children with HIV under the age of 16 years are entitled to a monthly government allowance.

198 Ministry of Health and Medical Industry, "On sanitary protection of the territory of Turkmenistan", Order No. 116 (26 December 1995). This order was prepared on the basis of Order No. 18 (12 December 1995) of the Vice-Chairman of the Cabinet of Ministers. In addition, the *Sanitary Code of Turkmenistan* (adopted 19 May 1992) regulates maintenance of the public health, including prevention of infectious diseases.

199 *Law "On health protection"* [Об охране здоровья граждан], Law No. 265-I (29 August 1996), Article 8.

200 Ibid., Article 14.

201 Cabinet of Ministers of the Republic of Uzbekistan, "On approving the list of social diseases and establishing privileges for people suffering from them" [Об утверждении перечня социально значимых заболеваний и установлении льгот лицам, страдающим ими], Resolution No. 153 (20 March 1997).

receive treatment for drug dependence at private facilities licensed to provide certain types of fee-based health services. HIV infection and viral hepatitis are also classified as "diseases posing a threat to others," and persons suffering from such diseases are also eligible to receive free health services at specialized facilities within the public health care system.[202]

In all project countries except Turkmenistan, via programmes funded by the Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund), all HIV-related care and support services are provided free-of-charge, including social and psychological counselling, social rehabilitation of PLHIV, assistance in securing employment (if needed), social assistance benefits, etc. The Global Fund-supported programmes also cover prevention and treatment of sexually transmitted diseases and provide (some) harm reduction services for drug users (obviously with considerable variation between the project countries).

State guarantees of free drug dependence treatment and HIV-related treatment, in the majority of project countries, is a positive feature. However, designating these conditions as socially dangerous or posing danger to others may reinforce stigma and discrimination that affect people living with these conditions. Furthermore, provision of free health care on the basis of residence permit and identification documents, limits access to health care for groups, that particularly need it, such as homeless people and people without identification documents.

In general, the existing health care infrastructure in the project countries is sufficient for providing universal access to prevention, treatment, care and support in relation to HIV infection. However, the accessibility of services is impeded by legislative restrictions (e.g. based on registered place of domicile) or by providing quality and confidential treatment only to those who can pay private service-providers. In addition, in many cases available services are of inadequate quality, undermining the value of the national concept of universal access.

Patients' rights

Patients' rights are set forth in the legislation of the project countries to some degree, which is a positive feature. However, the legislative review by the national expert groups indicates that national laws generally do not formalize specific rights such as a right to decline treatment, a right to participate in decision-making about treatment, and a right to full information. For example, in Tajikistan, the *Law "On Public Health Care"* lists patients' rights which include the following: a right to respectful and humane attitude on the part of health workers staff; the choice of a doctor including a family and attending physician; access to a lawyer or other legal representative to protect patient's rights.[203] This short list does not address issues such as a right to participate in selection of treatment options, a right to decline treatment, the protection of confidentiality, and a right to lodge a complaint about activities of health facilities to a court or other body, among others.

Although national legislation in the project countries normally includes provisions for confidentiality of patient's health information, the national expert groups report that these protective features of the law are rarely applied in practice, partly because there are no or few enforcement provisions and mechanisms. For example, according to the national expert groups, despite frequent breaches of confidentiality (particularly for stigmatized conditions such as HIV infection and drug dependence), health care workers are rarely held liable for disclosure of confidential information.

Generally, according to the law, medical information may be disclosed without a patient's consent if law enforcement agencies, prosecutor, the court or health care facilities present an official request. In some countries of the region, there is an obligation of health care staff to inform law enforcement agencies about overdoses and referrals for narcological assistance, a policy which creates an obvious reason for people who use drugs to avoid seeking health care services (or for people to seek emergency assistance in instances of overdose).

202 The list was adopted by the Cabinet of Ministers of the Republic of Uzbekistan, Order No. 96 (20 February 1997).

203 Tajikistan's *Law "On public health care"*, No. 419 (15 May 1997) Article 31.

The assessment done via this project highlighted the lack of free access to anonymous voluntary treatment for sexually transmitted infections (STIs). This is an essential drawback of the health care system hindering universal access to health care services. Early diagnosis and treatment of STIs can significantly lower possibility of HIV transmission, as STIs can cause ulcers and irritation of genital tissues and can increase the amount of HIV in bodily fluids, thereby increasing infectiousness. To take but one example, in Kazakhstan, according to the national expert group, health care facilities provide anonymous services only for a fee; as a condition of providing STI treatment free of charge, hospitals require recording and submission of information about sexual contacts under the threat of administrative sanctions. These barriers to health care services are often impossible to overcome for vulnerable populations and youth. When barriers to diagnostic and treatment contribute to a high level of STIs in the population, this creates an environment conducive to the spread of HIV.

4.1.2 DRUG DEPENDENCE PREVENTION AND TREATMENT

National programmes on drugs

National drug control programmes are political documents that define basic concepts and strategies for combating illicit drugs supply, reducing drugs consumption and mitigating the medical and social consequences of drug use. In all project countries, the concept underlying the programmes are based on the notion that consumption of illicit drugs is an illegal activity, be it a single episode of drug use by youths or the regular drug use by a drug-dependent person, even if accepting that drug dependence is a disease. In keeping with the approach that was dominant in the former Soviet Union, people who use and/or are dependent on narcotic drugs are frequently considered "socially unreliable" and "socially useless" and, worse, as criminals rather than persons that can benefit from treatment. Thus, the proposed strategies and interventions have mostly been a combination of attempted deterrence and behavioural coercion, even when it comes to treatment for drug dependence. This approach also manifests itself in the legislative regulation of drug dependence treatment: such treatment is regulated mainly under drug laws (with their focus on law enforcement) rather than in health-related legislation. In some of the project countries (i.e., Kyrgyzstan, Uzbekistan), statutory regulation of drug dependence treatment is laid out in three or four articles in the national drugs statute, rather than in health care legislation (i.e. statutes on narcological assistance).

Even when the issue of drug use is addressed through health legislation, it is too often the case that the response focuses on measures for drug dependence treatment that are of little effectiveness; instead of analysing why such measures are not working and changing them, it is drug dependent people who are blamed for not responding to treatment, with harsher regulatory measures then applied. In general, the drug control programmes concentrate on ineffective preventive interventions (such as random drug testing, one-time information campaigns, etc.). There still is little room for policies or initiatives that do not in some way reflect the conception of drugs and of people who use them as primarily subjects to be controlled and punished through the operation of the criminal justice system or similarly quasi-criminal and coercive measures.

Historically there has been little or no attention to harm reduction strategies in drug control programmes. However, in the recent years the project countries started implementing a more balanced approach, at least on paper. Kyrgyzstan was the first to embrace harm reduction strategies as an unalienable part of drug control policy and to clearly describe evidence-based interventions for protection of drug users' health in its National Drug Control Programme (2004-2010).

As this project's review identifies, on some issues, other project countries have also started reinterpreting their drug policies towards more evidence-based interventions in relation to both drug dependence treatment and a broader range of harm reduction and other health services for people who use drugs. Similarly, as the national expert groups' assessments demonstrate, there is a growing recognition that protecting and promoting the human rights of people who use or are dependent on drugs both reflect obligations under international law and makes good public health sense, particularly when faced with the very significant extent to which the HIV epidemic in the region is linked with risky drug-use practices. (For more detail, see the individual country reports in Part II.)

The leading role in the development and coordination of implementation of national drug control programmes belongs to national drug control agencies (DCAs) or similar bodies, which have as a primary mandate the enforcement of drug laws to prevent drug trafficking and consumption. In some countries, the DCA operates under presidential office (Tajikistan) or cabinet of ministers (Azerbaijan, Turkmenistan and Uzbekistan); in others, they are departments (committees) within ministries of interior (Kazakhstan and Kyrgyzstan; in the latter DCA was downgraded to a department in October 2009). The fact that these agencies do not clearly fall under the Ministry of Internal Affairs or the Ministry of Justice, but instead exist independently, sometimes results in the lack of clarity as to where they fit in the government hierarchy and to whose jurisdiction they are subject. These bodies have been created over the last decade, with the aim of making drug control policies more effective by increasing the countries' analytical capacity, better planning and coordination of interventions within and between countries in the region and globally. For these purposes, in addition to intelligence and law enforcement departments, they include units for primary prevention of illicit drug use, drug dependence treatment and rehabilitation.

The national DCAs certainly play a predominant role in shaping the overall approach to drugs. Some national programmes on drugs give DCAs the task of coordinating all activities related to drugs (including drug dependence treatment and prevention of drug use which are prerogative of the ministries of health and education, respectively). Even where DCAs are not involved in planning and managing drug dependence treatment, their interpretation of the dynamics of the drug-related situation in the country and the perceived effectiveness of various preventive and treatment interventions may result in policy and legislative changes that can affect access of the population to evidence-based preventive and treatment measures. .[204] As the mandates of the national drug control agencies are primarily defined in terms of combating drug trafficking and otherwise enforcing the criminal laws on drugs, this influence (the focus on control) is often felt in the areas of both preventing drug use and treating drug dependence. For example, the drug control agency and other law enforcement agencies often have largely unfettered access to ostensibly confidential patient information of people on registries of narcological facilities (people who use drugs and people who are dependent on drugs).[205]

As DCAs are primarily law enforcement bodies, not public health bodies, their involvement in matters of drug dependence treatment is not conducive to treating drug dependence as a disease and not a crime. As the review determined, for better results of drug dependence treatment and HIV prevention, it is recommended to remove the DCAs' authority in supervising, coordinating or in any way participating in treatment of drug dependence, which should be a purely medical matter.

Accessibility of quality drug dependence treatment

Drug dependence treatment services are regulated by orders, instructions and clinical protocols issued by Ministries of Health, as well as laws on narcological service (in Azerbaijan, Kazakhstan and Tajikistan). Usually drug laws and/or health care laws (in Kyrgyzstan, Turkmenistan and Uzbekistan) provide only a general legal basis for the access to treatment. Since the 1970s, all the project countries have established a network of narcological services with satisfactorily geographical access to inpatient drug treatment facilities.

As noted above, the state provides certain health services, including treatment for drug dependence, free of charge to the patient as a matter of law in all of the project countries, with the exception of Kyrgyzstan, which requires a co-payment by the patient for drug dependence treatment.[206] In practice, however, if a person wishes to undergo *anonymous* or fully confidential drug dependence treatment, or to receive treatment in a private institution, services are fee-based. In Kyrgyzstan and Tajikistan, drug dependence treatment can be provided by NGOs, while fee-for-service treatment is also available (i.e., anonymous treatment or treatment

204 For example, the prevention of drug dependence is one of the responsibilities of the Drug Enforcement Committee in Kazakhstan, and in educational facilities, it is the Ministry of Internal Affairs Inspectorate for Juveniles that is responsible for prevention of drug dependence among youth: see the full report of the national expert group of Kazahkstan [in Russian only, on file].

205 For example, in Turkmenistan, drug user registration is conducted following a 2008 Presidential Decree. According to the Decree, one of the main tasks of the National Drug Control agency is establishing "the unified database that contains information on the drug situation in the country, and the number of people who are registered as using drugs, and of people involved in drug dealing."

206 As noted, Kyrgyzstan is the exception insofar as there is co-payment by patients for certain medical services, pursuant to the "Regulation on co-payment for medical services provided by public health system operating in the system of unified payment", Government Government Resolution No. 363 (24 August 2007).

provided by private clinics). At the same time, inpatient treatment services in some countries may require that patients pay for or provide their own food and other necessities and sometimes medicines.[207]

A survey of 1200 people who used opioid drugs in Kazakhstan in 2006 indicated that existing treatment options hold little attraction for people who use drugs. Some people wish to undergo better quality or anonymous treatment; others are unable to pay fees that are imposed notwithstanding the state's guarantees of free treatment (one-third of those surveyed said they did not have funds to pay for treatment). According to the Kazakh national expert group, the few well-equipped drug treatment facilities in the country are unable to provide treatment and rehabilitation for all in need of it.[208]

In all the six countries, drug dependence treatment is mainlyaimed at full abstinence. According to the data provided by the national expert groups, treatment consists primarily of detoxification methods. For example, in Azerbaijan, detoxification and one small OST programme are the only treatment options available, with no psychotherapy-based treatments. The experts noted that there is unwillingness to undergo state-provided treatment voluntarily, and (unofficial) private treatment for drug dependence is widespread. Unwillingness to seek drug dependence treatment voluntarily is no doubt a result, in part, of the negative consequences of registration. Kazakhstan's national expert group reports that drug dependence treatment there consists of "detoxification, sensitizing therapy and comprehensive psychotherapy," but there are no standard protocols for these procedures. In Tajikistan, in addition to government-run detoxification programmes, NGOs provide rehabilitation and 12-step programmes. In all project countries, narcological service was built with no special attention paid to the gender aspects of treatment; for example, there are no special treatment programmes designed to take into account specific needs of women, including the lack of child care services.

Though the effectiveness of the narcological system is rarely officially evaluated, current drug dependence treatment methods appear to have a very low success rate — on average around 10-12% of patients succeeding in remaining drug-free a year later.[209] The lack of effectiveness has long been acknowledged and attempts have been made to counterbalance it by coercive measures (patient registration and non-voluntary treatment), on the premise that this will increase patients' adherence to the treatment and thereby result in a long-term abstinence from drug use. However, these coercive measures are not based on evidence and have only exacerbated the medical and social consequences of drug use; high relapse rates persist and semi-coercive admissions (with patients' "consent" for undergoing treatment "voluntarily" usually obtained under the threat of a referral to compulsory treatment) result in people breaking their treatment regimes, absconding and eventually avoiding treatment. Such inadequate and ineffective treatment and aftercare result in worse health for people who use drugs and their further marginalization and criminalization. Despite this, the project countries still maintain the above-mentioned "tools of coercion", although they differ how strictly they apply them.

Registration and reporting of people who use or are dependent on drugs

In all project countries, it is standard practice for narcological services to register the names and other information about people who have sought their services or have been presented there by law enforcement personnel, once drug use has been confirmed or drug dependence diagnosed. In most of the countries, there are two forms of registration: *preventive* registration of people who use drugs but do not have signs of dependence, with the purpose of monitoring and prevention of drug misuse (that may result in the development of drug dependence); and registration of people who are *dependent* on drugs for the so-called dispensary care. However, no specific, evidence-based interventions are provided to people on the preventive registry; in reality, prevention consists of periodic health check-ups with possible drug testing. Usually, preventive registration is done for one year. If, over one year of surveillance, there is no evidence of drug use, the person is discharged from the preventive registry.

Patients with drug dependence who have undergone treatment at a narcological facility or otherwise have used its services are registered with this facility. Registration happens both in cases of voluntary and involuntary treatment, based on diagnosis of drug dependence. Registration lasts for at least three years (Kyrgyzstan, Turkmenistan and Uzbekistan) and for up to five years (Azerbaijan, Kazakhstan and Tajikistan). During these periods, a patient is required to provide evidence of being drug-free. After 3-5 years of full abstinence, if confirmed by documented evidence, the patient is removed from the registry (by a decision of the facility's medical commission) and is considered to be fully recovered. Until the discharge from the registry, even if the patient has been drug-free for a year or more, he or she is considered to be ill (though with an illness in remission) and his or her rights can be subject to limitations.

While registration is, theoretically, needed for providing continuity of care, some legal provisions make it an instrument for imposing a variety of limitations of rights and discriminating against those registered – even after extended periods of abstinence from drug use. For example, all the project countries maintain a regulation that provides for denial of a driver's license to people registered as drug-dependent; similarly, there are lists of jobs that are prohibited to people listed on the registry. Registration may cause a person to lose custody of his or her children pursuant to a court order.[210] In Turkmenistan, registration with a narcological facility may be grounds for cancellation of a residence permit for a foreign national or stateless person.[211] In Uzbekistan, a person registered as drug-dependent may be denied access to higher education, as for enrolment one needs to present a medical form that includes a statement from a narcologist that one is not on the narcological registry.[212] In Tajikistan, if a person who is in the registry commits any crime, he or she is ordered to undergo compulsory drug dependence treatment in prison, whereas the same person may have avoided prison altogether had he or she not been on the registry.[213]

The registration system also threatens patient confidentiality if there are not rigorous controls of leaks of information. The expert group from Kazakhstan noted that provisions regarding confidentiality of drug dependence treatment and rehabilitation programmes are hardly ever observed. The 2006 survey of people who used opioids in Kazakhstan referred to above found that 55.5% of the 1200 respondents wanted to receive treatment for drug dependence, but feared doing so because of the registration system; 75.2% respondents were in favour of repealing narcological registration, since this leads to limitation of rights (e.g., employment problems, harassment by the police, attempts to incriminate with threatened charges for "possession of drugs", and forced cooperation with law enforcement agencies even including confessing to offences committed by other people).[214] The expert group from Kazakhstan therefore recommended providing health services to persons using drugs under conditions of complete anonymity.

In all the project countries, information on a patient registered with a narcological facility may be released upon official orders from judicial, law enforcement and health care agencies without consent of the person. Moreover, according to the national experts' reports, medical professionals are generally required to share information from the registries of drug users with police. For example, as mentioned above, the law of Tajikistan requires narcological facilities and health care providers to cooperate with police when rendering narcological assistance to persons suffering from drug dependence, in order to prevent activities that may threaten their own lives and health or those of other people.[215] In Turkmenistan, health care workers are obliged to inform law enforcement agencies about people who seek assistance in cases of overdose or drug dependence treatment.[216] In contrast, in Kyrgyzstan, health workers are not obliged to automatically inform law enforcement agencies about cases of overdose or drug dependence treatment, although they must still provide this information pursuant to an order from a court or upon demand by police or prosecutors. According to the expert group of Uzbekistan, national legislation does not explicitly require health workers to cooperate with police, but this practice exists: drug dependence treatment facilities habitually inform law enforcement agencies about persons seeking treatment. Some of the observations of the country reviewers indicate that corruption in the registration system makes it possible to avoid registration or to buy a false certificate of non-registration for applications to educational institutions or for employment. Besides its illegality, this option is likely to be unavailable to people with

207 E.g., see summary country reports for Tajikistan and Azerbaijan in Part II.

208 See the summary country reoprt for Kazakhstan in Part II.

209 Data provided by UNODC program coordinators. For example, official data from Tajikistan estimates a relapse rate exceeding 90%, with treatment being "successful" in only an estimated 6-8% of cases: Government of Tajikistan, "*Program on preventing narcotic addiction and improving narcological assistance in the Republic of Tajikistan, 2005-2010*", Resolution No. 113 (2 April 2005) [«Программа по профилактике распространения наркозависимости и совершенствованию наркологической помощи в Республике Таджикистан на период 2005-2010»].

210 For example, Turkmenistan's *Code on Marriage and Family*, Articles 70 and 115.

211 Turkmenistan's *Law "On migration"*, Law No. 30- III (7 December 2005), Article 16.

212 Information provided by the national expert group of Uzbekistan [on file].

213 Information provided by the national expert group of Tajikistan [on file].

214 See the summary country reoprt for Kazakhstan in Part II. For a discussion of relevant findings and analysis from some other former Soviet countries with similar systems, see: *The Effects of Drug User Registration Laws on People's Rights and Health: Key Findings from Russia, Georgia, and Ukraine* (Open Society Institute, October 2009).

215 Tajikistan's *Law "On narcological assistance"*, Law No. 67 (8 December 2003), Article 22.

216 Order of the Ministry of Health of Turkmenistan (14 October 2000).

addictions who live in poverty.

Compulsory drug dependence treatment

Compulsory treatment of drug dependence in one form or another exists in all six countries, and is regulated by legislative acts and instructions. Several of the project countries have specific legislation on compulsory treatment. In theory, pursuant to legislation in most of the project countries, a court may order compulsory treatment in two cases: for those who refuse to undergo voluntary treatment and whose behaviour disturbs public order or threatens the well-being of others, and for drug-dependent prisoners.[217] In at least one of the project countries (Tajikistan), the national expert group has reported that, notwithstanding such provisions, compulsory treatment is not implemented outside the prison settings because of the high cost and the lack of positive outcomes, although compulsory treatment is still implemented in correctional facilities.[218]

Project countries' national statutes generally give great latitude to authorities to force people into drug dependence treatment under a wide range of circumstances. For example, Uzbekistan's law allows for compulsory treatment for people with chronic alcoholism and drug dependence who (a) violate the "social order," (b) violate the rights of other people, or (c) pose a threat to the safety, health and morality of the population.[219] Tajikistan's law specifies that persons with drug dependence, substance and alcohol dependence must undergo treatment in government health facilities. Persons avoiding voluntary treatment may be ordered into treatment by the courts. If a person who uses drugs commits illegal acts, investigatory agencies may send him or her to a forensic narcological expertise which includes drug testing and clinical examination. If drug dependence is diagnosed and the medical commission recommends compulsory treatment , the court orders drug dependence treatment in the penitentiary system in addition to the custodial sentence.[220]

By law, the complaint about a drug dependent person's disorderly behaviour and the request to apply coercive measures can be submitted to the local police by relatives or other people affected by the person's behaviour. . The police investigate the allegations, and if confirmed, submit the findings to the local narcological dispensary for further clinical examination and a conclusion by the medical commission on whether the person indeed needs compulsory treatment of the dependence. Compulsory treatment may be ordered by the court for periods of 3 months to 2 years, depending on country's legislation. Turkmenistan is the only project country that still maintains the so-called treatment-labour camp *(лечебно-трудовой профилакторий)* run by the Ministry of Interior; other countries have compulsory treatment for drug dependent people under their Ministries of Health. Compulsory treatment is provided in a local narcological dispensary or other narcological facility specially designated for providing compulsory treatment. In most project countries, the progress of the treatment is reviewed at least every six months; based on the conclusions of the medical commission, the term of compulsory treatment can be reduced or terminated if there is evident progress.

In all the project countries, the courts can order drug dependence treatment for people during imprisonment, but not as an *alternative* to incarceration. As noted above (see Section 3), international drug control conventions allow states to provide for alternatives to incarceration for drug-related offences, including treatment options.[221] Ordering compulsory drug treatment as part of a prison sentence, as apparently happens in the project countries, raises the question of the availability and quality of care and treatment in prison and whether treatment and support continue when a person is released from prison

To ensure quality of treatment, some countries have recently started to develop standards and clinical protocols for the compulsory treatment of drug dependence (Uzbekistan and Kazakhstan). Although theoretically, the same clinical practices that are employed for voluntary treatment, should be used for coercive treatment, in reality no mechanism for enforcing these standards exists, which results in considerably worse standards of service provision for patients under compulsory treatment than for those who undergo voluntary treatment of drug dependence.

According to the national experts groups, in none of the project countries has a formal evaluation of the effectiveness and efficiency of the compulsory treatment been done. However, the general opinion of specialists and general public is that this "treatment" is a mere temporary isolation of the difficult patients and thus its only benefit lies in the fact that it "gives a break" to the patient's relatives or the community where he or she lives.

TABLE 3: Compulsory treatment of drug dependence outside of the prison system
(UNODC-ROCA, 2009, data provided by National Project Officers)

Country and authority with jurisdiction over treatment	Capacity (no. of beds) and percent of total narcological beds in the system	Length of compulsory treatment	Number of people in compulsory treatment and per cent to the total number of patients who undergone treatment in the facility	Procedure for referral for compulsory treatment. Frequency of progress review
Azerbaijan Ministry of Justice	In 2009, 600 beds for drug dependence treatment; no special beds for compulsory treatment.	3 months to 1 year. Term is determined by judge based on conclusions of the medical-narcological expertise.	4 people in 2008; 1person in January-June 2009	On the basis of court decision, following a medical-narcological expertise. Progress is reviewed every 6 months.
Kazakhstan Ministry of Health	In 2009, total number of beds: 5028, of which 2740 (54.5%) are used for compulsory treatment of drug and alcohol dependence.	6 months to 2 years. The term is determined by court based on conclusions of the medical-narcological expertise. .	746 people (10.9%) of 6816 people in total who underwent treatment in 2007; 709 people (13.1%) of 5408 in 2008 .	If a registered person with drug dependence avoids voluntary treatment a narcological facility can sent a request to law enforcement agency to refer the person to compulsory treatment. Progress is reviewed once in 6 months. Treatment may be terminated by court before the full term, if progress is evident, but no sooner than 6 months after the start of treatment. Treatment term may be no longer than 2 years or 3 years, if referred for a second time.
Kyrgyzstan Ministry of Health	No special beds	The term is up to 12 months, determined by court based on conclusions of the medical-narcological expertise.	3 people (0.5%) of 575 people in total who underwent treatment in 2007; 5 people (1.3%) of 385 people in 2008	The referral to compulsory treatment is done by a court, following request of relatives (i.e. if the person is considered to represent danger to society) and necessary legal proceedings, including narcological expertise. Progress is reviewed once in 6 months.

217 See more detailed information about implementing mandatory measures of medical nature, and a human rights analysis of those measures, in the individual country reports in Part II below.

218 See the country report for Tajikistan in Part II below.

219 Uzbekistan's *Law "On compulsory treatment of persons with chronic alcohol and drug dependence"*, Law No. 175-II (15 December 2000) [О принудительном лечении больных хроническим алкоголизмом, наркоманией или токсикоманией].

220 *Criminal Code of the Republic of Tajikistan*, Law No. 684 (13 November 1998), last amended by Law No. 97 (25 July 2005), Article 101; and *Law "On compulsory treatment of people with alcoholism and drug dependence"* (12 April 1991).

221 Demonstrating this flexibility, numerous countries have instituted various alternatives to imprisonment, including in some cases "drug courts" or "drug treatment courts" that offer people with drug dependence the opportunity to undergo a mandated treatment protocol in lieu of incarceration, although the design and implementation of some such programs raise questions about their efficacy as well as human rights concerns. Drug treatment courts attempt to reduce harm to the accused of non-violent drug-related offences by diverting them from the penal system and assisting in rehabilitation, but the fact that participants enter treatment under the threat of incarceration, or abstain from drugs to avoid sanctions, has serious implications for the human and legal rights of the offender. These include possible violations of the right to due process and the principle of presumption of innocence, considerations that should be addressed in the design of any such initiatives. Concerns have also been raised about whether the evaluations of drug treatment courts show them to be particularly effective, and whether resources are better spent on expanding access to voluntary drug dependence treatment services that are evidence-based. (For some additional definitions, see the Glossary in Appendix 5, and for some additional discussion, see: Legislating for Health and Human Rights: Model Law on Drug Use and HIV/AIDS, Module 1: Criminal Law Issues, including "Annex: Drug Treatment Courts" (Toronto: Canadian HIV/AIDS Legal Network, 2006), online at www.aidslaw.ca/modellaw.)

Tajikistan	According to national expert group, compulsory treatment for drug dependence is not enforced outside the correctional system.			
Turkmenistan Ministry of Health and Medical Industry	In 2009, 95 beds for treating elderly patients with drug dependence, which constitutes 7.4% of all narcological beds in the country (1290). Additionally, there are special treatment facilities for people with drug and alcohol dependence (treatment-labour camps) under the Ministry of Interior, where people are treated.	The term is 3-6 months, determined by court based on conclusions of the medical-narcological expertise.	197 people (1.7%) were treated involuntary in regular narcological facilities, out of all narcological patients (11,160), in 2007. In 2008, 1500 people were treated compulsorily in special facilities of the Ministry of Interior (in treatment-labour camps) .	Compulsory treatment is ordered by a court for people who violate public order, rights of others, or are a danger to security (including threat of violence), health and morale of population. The procedure includes a complaint by relatives or other party and necessary legal proceedings, including narcological expertise. Compulsory treatment could be inpatient and/or outpatient. Progress is reviewed every 6 months.
Uzbekistan Ministry of Health	In 2008,704 beds for compulsory treatment, which is 41% of all narcological beds (1718).	The term is up to 18 months, determined by court based on conclusions of the medical-narcological expertise.	12.7% of all people who underwent drug dependence treatment were treated compulsorily in 2007; 13.3% in 2008.	Referral is done by law enforcement bodies on their own initiative, or following a request of relatives, work colleagues, or narcological facilities and necessary legal proceedings, including narcological expertise. Treatment is ordered by court to those who violate public order, rights of others, or are a threat to security (including threat of violence), health and morale of the population. There are no rules for review of progress. The term may be shortened depending on the progress.

Opioid substitution treatment (OST)

Despite the advent of HIV, the quick spread of the infection among injecting drug users since the early 1990s, the emerging problem of fatal drug overdose, and numerous other health and social problems associated with drug use, the issue of the low effectiveness of conventional drug dependence treatment has rarely been discussed even in professional circles in the project countries. Moreover, recommendations from WHO, UNODC and UNAIDS[222] to implement opioid substitution treatment (OST) as an effective method of treatment for dependence on opioids, and a powerful means for HIV prevention among injecting drug users, have been ignored or directly opposed by lead specialists of narcology (e.g., in Uzbekistan) and, anecdotally, drug control or law enforcement agencies in some other countries.

The three UN agencies define OST as the medically-supervised administration of a prescribed opioid medicine to people with a dependence on a pharmacologically related opioid, "for achieving defined treatment aims".[223] Since the opioid substitute, usually a medicine such as methadone or buprenorphine, is given as a liquid or tablet, OST can enable people with opioid dependence to stop injecting and avoid the harms of using contaminated injection equipment. Especially for this reason, these UN agencies emphasize that OST "should be considered as an important treatment option in communities with a high prevalence of opioid dependence," and should be implemented as soon as possible in places where transmission of HIV through injection is significant.[224]

OST exists in one way or another in three of the project countries (Azerbaijan, Kyrgyzstan and recently established pilot projects in Kazakhstan). Kyrgyzstan has been a regional pioneer in the introduction and scaling up of OST: by the end of 2009, there were just under 1000 patients in OST programmes at 18 sites run by health care facilities under the Ministry of Health and 3 sites in the penitentiary system under the Ministry of Justice.[225] Until June 2009, a pilot OST project existed in Uzbekistan, at which time the government decided to discontinue it. This allegedly happened because of problems with the quality of services; however, efforts to address such concerns would have been a more productive response, rather than cancelling the project. OST remains unavailable in Tajikistan and Turkmenistan, both countries with thousands of people living with heroin dependence – although commitments to implement OST on a limited, pilot basis have been made in Tajikistan, with such programmes expected perhaps to start in 2010.

No legal obstacles for introducing and scaling up access to OST exist in Azerbaijan, Kazakhstan, Kyrgyzstan, Tajikistan and Turkmenistan.[226] As the table below shows, the major pharmaceuticals used for OST, methadone and buprenorphine, are allowed for medicinal use, though under strict control, in all these countries. In Uzbekistan, methadone is classified as an illicit narcotic drug, but buprenorphine is allowed for use as a medicine**.**

Table 6: Legal status of methadone and buprenorphine[227]

METHADONE				
Country	**Legal status**	**Whether on the national list of essential drugs**	**Legal provisions on import: national regulations**	**Comments**
Azerbaijan	National Schedule II of Narcotic Drugs: allowed to be used for medical purposes but with limited importation and strict control measures for its circulation (*National Law on the Legal Circulation of Narcotics and Psychotropic Substances,* № 959-IIQ *,28 June 2005)*	No.	Annually, quotas for procurement are defined by Ministry of Health and submitted to the Government, which issues decree allowing the procurement.	Procured by the state (Ministry of Health). The importation and use are based on provisions of the *National Law on the Legal Circulation of Narcotics and Psychotropic Substances,* № 959-IIQ *28 June 2005*
Kazakhstan	National Schedule II: List of Narcotics and Psychotropic Substances that are Used for Medical Purposes under Strict Control *(Law On Narcotics, Psychotropic Substances, Precursors and Counteracting Measures to Prevent Illegal Circulation and Abuse of this Substances, Law No 279, 10 July 1998)*	No	Same rules for importation for methadone as for other narcotic drugs under strict control: Government Decree issued annually on quotas for narcotic drugs, psychotropic substances and other controlled substances (precursors); estimates made by Ministry of Health and cleared by Drug Control Agency/ Ministry of Interior.	Imported for the first time in 2008, Procurement supported by GFTAM.

222 WHO, UNODC and UNAIDS, *Substitution maintenance therapy in the management of opioid dependence and HIV/AIDS prevention: WHO/UNODC/ UNAIDS position paper* (Geneva, 2004).

223 Ibid., para. 20.

224 Ibid., introduction and para. 70.

225 Data presented by Dr R. Tokubayev, Director, Republican Centre of Narcology, at the 4th Central Asian Inter-Parliamentary Conference on HIV, 6-7 October 2009.

226 For example, Tajikistan's *Law "On narcological assistance"*, Article 9. This article mentions "alternative substitution therapy for those with narcotic addiction."

227 Data as of 1 October 2009, as reported by UNODC National Project Officers.

Kyrgyzstan	National List No. 1: potentially dangerous narcotic drugs that can be used for medical purposes; allowed to be used for medical purposes but with limited importation and strict control measures for their circulation. *(Government of the Kyrgyz Republic, Decree On Narcotics, Psychotropic Substances and Precursors that are under Control in Kyrgyzstan, Decree No. 543, 9 November 2007)*	Yes	Government Decree on a one-time import of a limited amount of methadone issued annually.	Imported annually, procurement supported by GFATM.
Tajikistan	National List No. 2: Narcotic-contained plants and substances that are especially dangerous but could be used for medical purposes. Circulation limited and strict control measures applied. *(Government of the Republic of Tajikistan, Decree On Narcotics, Psychotropic Substances and Precursors, No. 390, 21 September 2000)*	No	No documents regulating import. In principle, to procure methadone the same regulations should be applied as for procurement of other narcotic drugs used in medicine (e.g., morphine)	Not imported.
Turkmenistan	List of Narcotics and Psychotropic Substances (used for medical purposes) with limited circulation and control measures. (*Presidential Decree "On approval of the lists of narcotics, psychotropic substances and precursors", No. 9192, 13 November 2007).*	No	No special provisions developed. In principle, to procure methadone the same regulations should be applied as for procurement of other narcotic drugs routinely used in medicine (e.g., morphine)	Not imported.
Uzbekistan	List of Narcotic Substances whose Circulation in the Republic of Uzbekistan is Prohibited (*List I Illicit Narcotics, Decree of the State Drug Control Commission of the Republic of Uzbekistan, No. 3, 22 May 1998).*	No	As a general rule methadone cannot be imported since it is prohibited for circulation in the country (List I).	Methadone was imported for the OST pilot project twice, in 2006 and 2007, with support of GFATM, Decree No. 7/3 of the State Commission on Drug Control (September 2003).

BUPRENORPHINE				
Country	**Legal status**	**Whether on the national list of essential drugs**	**Legal provisions on import: national regulations**	**Comments /references**
Azerbaijan	National List II of Psychotropic Substances: potentially dangerous psychotropic substances; allowed to be used for medical purposes but with strict control measures (*National Law on the Legal Circulation of Narcotics and Psychotropic Substances, № 959-IIQ, 28 June 2005)*	No	No special provisions.	Buprenorphine is not imported.
Kazakhstan	National Schedule II: List of Narcotics and Psychotropic Substances that are Used for Medical Purposes under Strict Control *(Law On Narcotics, Psychotropic Substances, Precursors and Counteracting Measures to Prevent Illegal Circulation and Abuse of this Substances No 279, 10 July, 1998)*	No	Same rules for importation as for methadone and other narcotic drugs under strict control.	Buprenorphine is not imported but is registered by the Ministry of Health.
Kyrgyzstan	National List III of Psychotropic Substances: potentially dangerous psychotropic substances; allowed to be used for medical purposes but with strict control measures for their circulation, except when they combined with other (non-controlled) substances. (Government of the Kyrgyz Republic, *Decree On Narcotics, Psychotropic Substances and Precursors that are under Control in Kyrgyzstan, Decree No. 543,9 November 2007).*	No	None. Theoretically can be imported in the same fashion as methadone and other narcotics under control.	Buprenorphine is not imported.
Tajikistan	National List No. 3: Substances with a certain level of risk of harms if used but that could be used for medical purposes. (*Government of the Republic of Tajikistan, Decree On Narcotics, Psychotropic Substances and Precursors, Decree No. 390, 21 September 2000).*	No	None. Theoretically can be imported more easily than methadone (as other psychotropic substance procured by the Ministry of Health).	Buprenorphine is not imported.
Turkmenistan	National List of Narcotics, Psychotropic Substances and Precursors (used as pharmaceuticals in medicine) with limited circulation and some control measures (*Presidential Decree "On approval of the lists of narcotics, psychotropic substances and precursors", No. 9192, 13 November 2007).*	No	None	Buprenorphine is not imported.
Uzbekistan	National List of Narcotic Substances with Limited Circulation in the Republic of Uzbekistan (List II, *Decree of the State Drug Control Commission of the Republic of Uzbekistan, No. 3, 22 May 1998).*	No	Imported based on annual request by Ministry of Health, cleared by Drug Control Agency, and the Government Decree issued for procurement of annual quota.	Imported twice (2006 and 2007) with financial support from GFATM.

The expert groups underlined that OST programmes are not regulated in the statutes of any of countries where they exist; mostly these programmes function on the basis of ministerial orders and instructions, which makes them more vulnerable to changes in political environment. Furthermore, access to these programmes is extremely limited because this treatment method is not institutionalized and still is run on a pilot basis with funding provided mostly by the Global Fund (except in Azerbaijan where the two OST sites are financed by the Ministry of Health but with very low coverage). Meanwhile, WHO, UNODC and UNAIDS produced a guide that could assist countries in setting the national targets for the access to OST which would make a positive impact on general health of the patients and contribute to the containment of HIV spread among general population.[228]

In addition, information from the country reports indicates that protocols used in these small-scale programmes could be improved to comply with best practices. For example, regulations should be drawn to prohibit reducing a patient's methadone dosage in order to punish a patient, as reportedly occurs in Azerbaijan. Similarly, provisions and protocols should be developed that would allow for people with stable results from the treatment to have the opportunity to take their methadone at home and not have to report to a narcological facility every day. On a positive note, the countries that do have some access to OST do not, at least on paper, limit the period during which a person can remain in treatment. However, the overall limited availability of these programmes is of great human rights and public health concern.

228 WHO/UNODC/UNAIDS, Technical Guide for countries to Set Targets for Universal Access to HIV prevention, treatment and care for injecting drug users (2009), online via http://www.who.int/hiv/topics/idu/en/index.html.

Table 5: Status of OST provision in the project countries (2009)[229]

Country	Date stated and location of first sites	No. of patients in first year	No. of sites as of Dec. 1, 2008	No. of patients as of Dec. 1, 2008	No. of sites by Oct. 1, 2009		Comments
					Location, no. of patients, and pharmaceutical used	Total no. of patients	
Azerbaijan	January 2004 National Narcology Centre in Baku.	60	1	100	2 sites (both in Baku): National Narcology Centre: 101 patients. National AIDS Centre: 15 patients. Methadone only.	116	OSTscale up is currently under consideration by Ministry of Health.
Kazakhstan	November 2008. Drug treatment clinics (dispensaries) in Temirtau and Pavlodar.	50	2	50 (25 at each site)	2 sites: drug dependence treatment clinics in Temirtau and Pavlodar (25 patients each). Methadone only.	50	There are plans in 2010 to increase the number of patients to a maximum of 100 per site.
Kyrgyzstan	2002 Two pilot sites in Bishkek and Osh city.	56 (Bishkek), 52 (Osh)	16 (including 1 site in Prison #47)	Total of 1569 patients since 2002. At the time of report: 829 patients outside prison, plus 97 patients receiving OST in Prison #47.	18 sites, located in narcological dispensaries in Bishkek and Osh, at the provincial AIDS centre in Osh and at Family Medicine Centres: ▪ 4 sites in Bishkek (260 patients) ▪ 7 sites in Chui oblast (335 patients) ▪ 5 sites in Osh city and Osh oblast (204 patients). 2 additional sites in pre-trial detention facility #21 (SIZO) and one site in Bishkek (55 patients). Methadone only.	926 (including about 100 in prisons)	Plans for expanding the access: new sites in SIZO #25 in Osh city and other prisons, and three community-based sites in Jalalabat, Uzgen and Kyzyl-kiya. .
Tajikistan	None	None	None	None	None	None	Plans of the Ministry of Health to start two OST (methadone) pilot sites in Dushanbe (120 patients) and Khujand (80 patients) by beginning of 2010
Turkmenistan	None	None	None	None	None	None	No definite plans for OST introduction
Uzbekistan	February 2006. Tashkent City Narcological Dispensary	125 (100 on buprenorphine, 25 on methadone)	1	142	1 site (Tashkent): 142 patients (57 on methadone and 85 on buprenorphine)	0	Was cancelled in June 2009.
Total in all 6 countries	**n/a**	**n/a**	**20 sites**	**1060 patients**	**23 sites**	**1092 patients**	

229 Data as of 1 October 2009, as reported by UNODC National Project Officers.

Management of overdose

People who are dependent on heroin (or other opioids) are at high risk of overdose, especially if they inject heroin of unknown toxicity or potency, or consume heroin concurrently with other substances. Overdose in turn carries a high risk of death. WHO, UNAIDS and UNODC estimate that, partly because of overdose, the mortality rate for people with heroin dependence is up to 20 times higher than that of non-heroin-dependent people of the same age.[230] Death from overdose usually occurs within a few hours of administration of the dose in question.

It should be noted that ensuring access to opioid substitution therapy is one of the most effective ways to reduce deaths from overdose among people living with heroin dependence; another reason for its introduction and scale-up in the project countries.

In many countries, it is established practice to authorize emergency medical teams, hospital emergency rooms, and drug dependence treatment facilities to use the medicine naloxone to manage heroin overdose.[231] Naloxone is an opioid antagonist (i.e. it blocks opioid receptors in the nervous system), reducing the effects of heroin; it is quick-acting when administered by injection.[232] Naloxone is on WHO's Model List of Essential Medicines.[233] Naloxone has been used for many years in many countries for prevention of overdose death without evidence of negative side effects or outcomes.[234] Some experts have argued that friends and family members of heroin users or heroin users themselves should be allowed to carry naloxone for use in overdose emergencies they might witness, since many overdose deaths occur in the presence of friends or family before emergency health personnel arrive.[235]

In some of the project countries, naloxone may be used for overdose management. In the countries where naloxon is registered for medicinal use, it is used as a drug for an emergency intervention and must be prescribed by a physician. In Kazakhstan[236] and Kyrgyzstan,[237] naloxone is included in the national list of essential medicines, and is used as an antidote for poisoning and in emergency aid. In Tajikistan,[238] naloxone is registered as a medicine, but it is also a controlled substance; this means that it could be used in medical facilities, but it cannot be handed out to people who use drugs and outreach workers for prevention of overdose. In Turkmenistan, naloxone is not registered and is not used for medical purposes. In Uzbekistan, until 2009 naloxone was not on the list of essential medicines, and therefore was not procured by the government (however, according to the experts, there were no limitations for its use). In 2009, the government of Uzbekistan made arrangements to procure naloxone, which is now available for overdose prevention and is distributed to health care facilities.[239] In Azerbaijan, according to the expert group report, naloxone cannot be imported into the country officially, and it is not procured by the government.[240] In none of the project countries where it is registered is naloxone currently available to outreach workers or to people who use drugs for purposes of using it in emergencies. The failure to take advantage of this life-saving treatment is a matter of urgent public health importance.

4.1.3 PREVENTION AND TREATMENT OF HIV INFECTION

National programmes on HIV and AIDS

National programmes on HIV/AIDS have been in place in the project countries for some time. However, at the outset, these plans and strategies rarely contained adequate, comprehensive HIV prevention provisions, and until recently did not touch upon populations considered at higher risk of infection. More often,

230 WHO, UNAIDS and UNODC, *Position paper*, para 4.

231 J. Strang et al., "Emergency naloxone for heroin overdose: Should it be available over the counter?" (editorial), *British Medical Journal* 2006; 333:614-615.

232 UNODC, "Reducing the harm of drug use and dependence (Treatment paper)" (Vienna: UNODC, 2007).

233 WHO, *Model List of Essential Medicines*, 15th ed. (Geneva: WHO, 2007), available via www.who.int.

234 Ibid.

235 Ibid.

236 The list is adopted by the Order of the Ministry of Health of the Republic of Kazakhstan, Order No. 883 (22 December 2004).

237 Government of the Kyrgyz Republic, "*On adopting a List of Essential medicines in the Kyrgyz Republic*", Resolution No. 759 (31.October 2006).

238 Ministry of Health, "On development of the narcological assistance in the Republic of Tajikistan," Order No. 485 (7 August 2006).

239 See country report of Uzbekistan in Part II.

240 See country report of Azerbaijan in Part II.

national programmes concentrated on proper procedures in hospitals to prevent occupational exposure of health care workers and to sterilize medical equipment between uses, as well as additional benefits for health care personnel caring for people with HIV/AIDS. A review of current national programmes shows that, more recently, most of the project countries have started implementing more evidence-based interventions and are moving beyond the initial reluctance to deal openly with issues of HIV transmission related to sexual activity and drug use. (For more detail, see the individual country reports in Part II.) In five of the six project countries, the national programme mentions HIV prevention among people who inject drugs as an area of concern and in some there is explicit reference to certain harm reduction programmes as part of the country's HIV strategy (e.g., Azerbaijan, Kyrgyzstan, Kazakhstan, Uzbekistan and Tajikistan). However, there is often little reference to prisons specifically as a setting in which people face additional risks of HIV and hence require additional attention.

In the project countries, it is most often the Ministry of Health that develops the national HIV programme; some countries have made more concerted efforts than others to involve people living with HIV and groups particularly affected by HIV in that process. The national expert groups pointed to a number of concerns with current national HIV programmes, including the following common issues:

- National programmes are often declarative in nature, amounting to simply statements of the government's policy intentions or desired outcomes, but with no real force. In particular, national programmes or strategies often lack a clearly defined budget, and do not make clear provisions for allocating the funds necessary to implement the programmes and actions contemplated.
- More specifically of relevance to this project, even where there may be general reference to people who inject drugs as a vulnerable population of concern and/or general reference to harm reduction, there are rarely provisions about particular HIV prevention measures needed to address the health of people who inject drugs and of people in prison; rarely are there targets for coverage by and scale of evidence-based preventive interventions for these groups.
- There is generally insufficient participation of civil society, particularly groups that might be at higher risk of HIV infection, in the development of the national HIV programmes and their implementation.
- The national HIV programmes rarely address the issue of respecting, protecting and fulfiling the human rights of vulnerable groups, and are often weak when it comes to identifying clearly the actions needed to protect and promote the health of vulnerable groups.

The information about legislation and policies with regard to some important elements of HIV prevention and treatment, including for people who inject drugs in particular, is outlined below. (The situation with regard to HIV prevention and treatment for people in prison, including incarcerated people who use or are dependent on drugs, is discussed in more detail separately in the section on prisons.)

HIV testing and counselling

Informed consent

In all of the project countries, as a general rule, the law requires consent for HIV testing, but practices of obtaining informed consent vary widely. There are also wide exceptions to the principle of voluntary HIV testing stipulated in the law, with regulations listing categories of people subject to involuntary testing (see more detail below).

Kyrgyzstan is the only one of the project countries in which "informed *written* consent" is explicitly required by the law.[241] In other countries, the law requires consent, but does not always stipulate how consent is to be obtained. An order of Kazakhstan's Ministry of Health states that testing is to be done only with the informed consent of the patient and accompanied by counselling.[242] In Turkmenistan, the law guarantees access of everyone to "voluntary, confidential, anonymous HIV testing"[243], but does not explicitly require informed consent to HIV testing. In Uzbekistan, people are entitled to voluntary, anonymous

241 In accordance with Article 7 of Kyrgyzstan's *Law "On HIV"*, testing is possible only with the written consent of the person or of his/her legal guardian. Compulsory testing is allowed pursuant to an official request of an investigator/prosecutor or court order.

242 Ministry of Health of Kazakhstan, Order No. 227 (9 March 2004).

243 *Law of Turkmenistan On prevention of HIV*, Article 5. The wording of this article and similar provisons in some other project countries state simultaneously that testing is "anonymous" and "confidential"; whether there is access to any testing that is entirely anonymous remains unclear.

HIV testing with guaranteed confidentiality.[244] Regulations approved by the Chief State Sanitary Physician of the Republic state patients' rights to anonymity and confidentiality of testing as well as the accessibility of testing, and the requirement of pre- and post-test counselling.[245] In 2008, Tajikistan's Ministry of Health adopted detailed guidelines on HIV testing, which provide for free anonymous or confidential HIV testing, with informed consent, which can be written or oral. Pre-and post-test counselling is supposed to be provided in each case of HIV testing. The guidelines also provide for wide exceptions from the principle of voluntary testing, and list groups of people subject to mandatory testing.[246]

Counselling

Counselling to accompany HIV testing is provided for by law or policy in most of the project countries[247], but in practice may be limited by shortages of trained counsellors. Confidentiality is subject to legal guarantees in some countries, but virtually all of the country reports note that information on HIV status can be and is shared, without patients' consent and often without a justification (such as where it may be in the best interests of a patient), with law enforcement representatives and in health facilities beyond AIDS centres.

Confidentiality and access to anonymous testing

Anonymous HIV testing exists in at least some of the project countries, but more often than not, only for a fee. According to the national expert groups' reports, anonymous HIV testing is widely available only in Kyrgyzstan and Kazakhstan.[248] In both countries, anonymous testing providers do not request identification documents or the patient's name and address; testing is done using a code, according to which the result is given to the patient. Coded results about each newly identified case of HIV infection are immediately sent to the local epidemiological control facilities. In Azerbaijan, in the case of anonymous HIV testing (which is done on a fee-for-service basis), no counselling is provided. In Tajikistan, the new 2008 protocol lays out procedures for free, anonymous HIV testing.[249]

Generally, in the situation where HIV testing has been done nominally (i.e., the person's name and identifying information are recorded), such information may be given to the law enforcement agencies only pursuant to an official request from an investigator/prosecutor's office or a court order. In other cases, personal identification information is confidential.

Involuntary HIV testing

As noted above, the general rule is that HIV testing should be done only with the consent of the person being tested. However, in the project countries, there are many circumstances in which, pursuant to statute or other instrument, HIV testing is made either *mandatory* or *compulsory* by law, and there are in some cases vaguely-worded legal instruments that enable or encourage what often amounts in practice to *coercive* or *quasi-coercive* testing. We consider these three categories here.

The distinction between *mandatory* and *compulsory* testing is often confused, including by the incorrect use of such terms as if interchangeable; when laws are not clearly drafted, this compounds the uncertainty

244 *Law "On HIV"*, Article 3.

245 Chief State Sanitary Physician, "Sanitary rules and procedures for HIV/AIDS testing and treatment for people with HIV/AIDS" [Санитарные правила и нормы по медицинскому освидетельствованию на ВИЧ/СПИД и организации медицинской помощи больным ВИЧ/СПИД], No. 0187 (6 October 2005) [hereinafter "Sanitary Rules"].

246 Government of Tajikistan, "On Procedure of testing in order to identify persons infected with HIV, their registration, medical assistance to and preventive care of people living with HIV, and the list of people obliged to undergo mandatory confidential HIV testing on epidemiological indications" [Об утверждении Порядка медицинского освидетельствования с целью выявления заражения вирусом иммунодефицита человека, учета, медицинского обследования ВИЧ-инфицированных и профилактического наблюдения за ними и Списка лиц, подлежащих обязательному конфиденциальному медицинскому освидетельствованию на ВИЧ-инфекцию по эпидемиологическим показаниям], Resolution No. 171 (1 April 2008).

247 No information was available regarding the availability of pre- and post-test counselling in Turkmenistan.

248 Ministry of Health of Kazakhstan, Rules "Regarding Medical Examination of Citizens for the Detection of Infection with Human Immunodeficiency Virus " [Об утверждении Правил медицинского освидетельствования на выявление заражения вирусом иммунодефицита человека], Orders No. 575 (11 June 2002) and No. 227 (9 March 2004). There were reportedly 326 facilities for anonymous HIV testing in the country at the time of the national expert group's report in 2008; in the first half of 2007, 3.4% of people receiving HIV testing in Kazakhstan were tested anonymously: information provided by national expert group of Kazakhstan [on file].

249 Government of Tajikistan, "On Procedure of testing in order to identify persons infected with HIV, their registration, medical assistance to and surveillance of people living with HIV, and the list of people obliged to undergo mandatory confidential HIV testing on epidemiological indications", Resolution No. 171 (1 April 2008).

of how best to characterize the law.[250] The distinction between these is as follows:

- First, certain laws or decrees may require certain categories of people to undergo HIV testing if they seek for some benefits/status from the state (e.g., entry visas, residence or work permits for foreigners) or engage in some activity (e.g., being employed in certain jobs). In such circumstances, HIV testing is *mandatory* as a condition of acquiring the benefit or engaging in the activity. The person may refuse to undergo HIV testing, and thereby forfeit the benefit or forego the activity, but he or she will not be subject to some other penalty and thus has an option that allows him or her not to be tested.

- Second, certain laws or decrees may provide for HIV testing that is *compulsory* – that is, the person has no choice but to be tested (e.g. pursuant to an order by a court or a police/investigative body during a criminal investigation), and may be physically restrained through the use of force by the state in order to perform testing or maybe otherwise subject to some penalty by the state if s/he refuses or resists testing (e.g. fine or imprisonment).

In addition, there is a third characterization of some circumstances of HIV testing that can be observed in the project countries – namely, *coercive* or *quasi-coercive* testing. In such cases, although being tested for HIV is not *mandatory* as condition of obtaining a certain benefit or status, and is not *compulsory* in that there is no clearly prescribed penalty that the state can use to enforce testing, it is nonetheless HIV testing that is not fully voluntary. While the national HIV laws in the project countries may only explicitly mention mandatory or compulsory testing for HIV in some limited circumstances (e.g. mandatory testing of blood donors or foreign nationals seeking entry, or compulsory testing of accused persons in criminal proceedings), they also generally fail to prohibit explicitly the broader application of involuntary testing. And even where law or policy may on paper indicate that HIV testing should be done voluntarily and with informed consent, practice may be different – and the law or policy may have some effect in encouraging testing that is not done with fully informed consent. Thus, it is often the case that ministerial or departmental guidelines, orders or instructions expand the categories of people who are at risk of being effectively *coerced* into being tested for HIV, when such directives instruct health care providers or other personnel to test people in these categories. For example, where regulations (e.g. governmental decrees or ministerial orders) mandate health care service providers to pursue HIV testing with certain categories of patients (e.g. pregnant women, drug using/dependent people, those with STIs, etc.), the underlying laudable goal of this approach – the so-called "provider-initiated" HIV testing – is to increase access to HIV prevention, treatment and care, particularly for those thought to be most at risk of HIV. How such regulations are worded, and how they are understood and applied by health care providers, can vary significantly. While such regulations do not impose a legal obligation on the patient to be tested for HIV, their language does not always give details of service providers' duties and patients' rights to decline testing. This contributes to the prospect of HIV testing being done without the patient's consent, or even without informing him or her that the test is going to be done or already has been done, since consent is simply assumed in the absence of any objection. This raises ethical and human rights concerns.

The following examples from national legislation in the project countries reflect the mixture of various types of regulations that directly or potentially allow for HIV testing to be upon pain of penalty for refusing (*compulsory* testing), mandate testing HIV-negative as a condition of obtaining certain benefits or status (*mandatory* testing), or require certain personnel to undertake HIV testing vis-à-vis certain groups without clearly insisting on the need for informed consent (effectively encouraging testing that is *coercive* to some degree):

Mandatory HIV testing

- All of the project countries require mandatory HIV testing of blood, organ and tissue donors; this is in accordance with internationally agreed best practices and is not objectionable.

All of the project countries also impose *mandatory* HIV testing for foreign nationals (with the exception of Azerbaijan), and as a condition of employment for people working in certain jobs (and it is a common practice by employers), as well as in a number of other circumstances not in accordance with best practices and international human rights norms.

- In Azerbaijan, the national HIV law provides for mandatory HIV testing only in the case of blood and tissue donors. However, subsequent orders of the Ministry of Health have made HIV testing mandatory at least for people working in the food sector. [251]
- In Kyrgyzstan foreign citizens and stateless persons are required to get an HIV test after arrival in the country and during annual preventive medical examinations, if there is an agreement with the person's state of citizenship on requiring HIV certificates. Foreigners are subject to administrative deportation from Kyrgyzstan only in the case of deliberately evading obligatory testing. According to a special list of jobs, HIV screening is carried out prior to employment in certain positions, and employees on this list are also obliged to undergo periodic health check-ups; the list includes healthcare personnel.[252]

- In Kazakhstan, foreigners and military personnel must undergo HIV testing. Military personnel must be tested upon entering the military service and 6 months later.[253] The legislation of Kazakhstan does not prohibit employers from requesting HIV status certificates from their employees. Thus, certain employers may do it.

- The law of Uzbekistan mandates testing for HIV (and other STIs, tuberculosis and drug dependence) before marriage.[254] If testing determines that one or both parties planning to marry have one or more of the above conditions, registration of marriage is done after confirming awareness of both parties about the results of these tests. Military conscripts and other personnel, and students of military schools, are subject to mandatory HIV testing; if found HIV-positive, they are dismissed from the educational facilities and the armed forces.

- In Tajikistan, mandatory HIV testing is conducted for certain categories of employees on the basis of "epidemiological indications," as a pre-condition of employment and at regular check-ups: medical doctors and nurses who work at AIDS centres and other healthcare facilities who work with people living with HIV; health care staff of medical labs that do HIV testing; health care staff who deal with blood; and tattoo providers.[255] Military personnel and students at military schools are subject to mandatory testing.[256] If employees of certain professions and positions are found to be HIV-positive, they must be transferred to a different occupation or work. If these workers refuse to undergo HIV testing, they may be dismissed from work.

- In Turkmenistan, certain workers of public health bodies (those whose jobs involve working with blood) are subject to mandatory HIV testing as a condition of their employment. A regular medical examination, including HIV testing, is also required for medical personnel who carry out diagnostic tests for HIV, provide medical care and preventive interventions to persons with HIV and AIDS, or have contacts with blood and other materials from infected persons.[257]

As noted from the above entries, HIV testing is required as part of recruitment to certain kinds of employment. Pre-employment HIV testing, and testing of employees as a condition of ongoing employment, exist in all of the project countries in one form or another. Generally, pre-employment HIV testing is required for certain professions, such as health care workers, people working in the food industry and/or military personnel. In addition to this, public offices and private enterprises can mandate their employees to undergo regular medical checkups, including HIV testing. In none of the project countries is there a prohibition on demanding HIV testing of employees.

Compulsory HIV testing

- In Kazakhstan, people are subject to "mandatory [*sic*] confidential medical examination for detecting HIV infection" if there are "substantial grounds" to think that they may be infected with HIV,

250 See the Glossary in Appendix 5 for the definitions of *mandatory* and *compulsory* testing, and the distinction between them.

251 Azerbaijan's *Law "On HIV"*, Article 7; Ministry of Health, Order No. 157 (23 October 1997).

252 *Law "On HIV/AIDS"*, Article 8; Government of the Kyrgyz Republic, "Rules for medical examination to detect HIV, medical registration and observation of people with positive and ambiguous HIV tests in the Kyrgyz Republic", Government Resolution No. 296 (25 April 2006).

253 Joint Order of the Ministry of Health No. 562 (4 November 2005) and the Ministry of Defence No. 342 (19 September 2005).

254 Regulation "On Medical Testing of Persons Planning to Marry", Regulation No. 365, Annex 1 to the Resolution of the Cabinet of Ministers, "On Approving the Provision of Medical Testing of Persons Planning to Marry" (25 August 2003).

255 Government of Tajikistan, "On Procedure of testing in order to identify persons infected with HIV, their registration, medical assistance to and surveillance of people living with HIV, and the list of people obliged to undergo mandatory confidential HIV testing on epidemiological indications", Resolution No. 171 (1 April 2008). Appendix 3, List of professions and positions that have to undergo mandatory HIV testing.

256 *Law of Tajikistan "On counteracting HIV/AIDS"*, Article 9.

257 *Law on prevention of HIV,* Article 11.

pursuant to an order by a health care facility, prosecution and investigation agencies or a court.[258] (Despite the use of the term "mandatory", the testing is in fact compulsory when ordered.) HIV testing is required of persons with diseases that pose a "serious hazard" to others (which includes HIV infection, viral hepatitis and tuberculosis),[259] and persons suffering from mental disorders who have committed "socially dangerous acts" (i.e. administrative or criminal offence) are also subject to compulsory testing.[260] Furthermore, the *Code of Administrative Offences* imposes administrative liability, punishable by fines, for avoiding medical examination or treatment in the case of a person with a disease that can be a "serious hazard" to others.[261] (It should be noted that all health-related legislation, including normative acts, ministerial orders, etc., is currently under review in Kazakhstan as a result of a new health code adopted in September 2009.)[262]

- In Kyrgyzstan, compulsory HIV testing may be conducted by court order based on an application by the police or public prosecutor; nobody but the police officer who initiated compulsory testing or the public prosecutor has the right to receive the results of the test.[263] Even when conducting HIV testing without the consent of the patient, medical workers are still under a duty to provide pre- and post-test counselling, although obviously the objective of ensuring informed *consent* to the test is irrelevant in such circumstances.

- In Uzbekistan, it is an administrative offence for a person to avoid testing for HIV or STIs if there is "sufficient information" [достаточные данные] to believe he or she is infected, as well as for a person to refuse to disclose the source of infection with HIV or an STI.[264] In addition, compulsory HIV testing may be conducted when requested by police. Testing is often imposed on sex workers and people who use drugs.[265]

<u>*Coercive or quasi-coercive HIV testing*</u>

- In most of the project countries, regulations or ministerial instructions mandate health care professionals to conduct HIV testing with various groups, including people who use drugs, in the context of their contact with the health care system. Because of the vagueness of legislation with regards to patients' rights, such directives easily contribute to the infringement of people's human rights in the form of HIV testing done without informed consent. In some cases, people with STIs and homeless people are also named as such target groups for whom HIV testing is instructed.

- In Tajikistan, service providers are obliged to offer counselling and testing to persons with symptoms of HIV infection or AIDS, or symptoms of diseases associated with HIV/AIDS. The following groups of patients are specified: patients with clinical indications associated with HIV infection (fever, diarrhoea, loss of body mass, etc); patients diagnosed with, or suspected of having, certain diseases (e.g., Kaposi's sarcoma, tuberculosis, hepatitis B and C, etc.); patients who regularly receive blood transfusions; patients who have received donated blood or organs; and children born to mothers living with HIV. In addition, certain individuals considered to have "epidemiological indications" of being at risk of HIV are also to be targeted for HIV testing, as are pregnant women, people who use drugs, STI patients, patients with tuberculosis, people in prison and conscripts. Tajikistan is unusual in the region in its approach to this provider-initiated testing, in that the instructions explicitly state that consent to testing is required (which is consistent with pre-existing law).[266]

- In Turkmenistan, the vague wording of regulations and ministerial instructions and the lack of elaboration on service providers duties and responsibilities as regards patients rights allow for varying interpretations on how to apply them. It may lead to the situations when the so called "mandatory confidential HIV testing" that is applied to patients receiving treatment for drug dependence, patients with tuberculosis, hepatitis, and STIs, prisoners, sex workers, men who have sex with men (MSM), as well as to pregnant women and newborns (if the mother is HIV-positive or based on clinical indications) is becoming in fact involuntary (these people may be not informed about being subjected to HIV testing nor their consent for testing is being asked). [267]

- In Azerbaijan, orders of the Ministry of Health have identified the following people as targets for HIV testing to be pursued by health care providers: pregnant women, people who use drugs, people in prison, sex workers, men who have sex with men, and patients with tuberculosis or STIs.[268]

Involuntary disclosure of sexual partners

Refusal of the person with HIV (or other STI) to identify sexual partners can result in criminal or administrative charges in Turkmenistan and Azerbaijan. In several of the countries, people can also be charged with an administrative offence if they refuse treatment for a sexually transmitted infection. Regulations also require HIV testing of people identified as sexual contacts of persons living with HIV.[269]

HIV prevention for people who use drugs: NSPs and outreach

As shown above, rarely do national HIV laws specifically address HIV prevention among people who inject drugs, a population that is among the most vulnerable in the region. However, needle and syringe programmes (NSPs), a key HIV prevention intervention, exist in all countries with the exception of Turkmenistan. More often, these programmes are mandated by regulations and other implementing legislation, but sometimes they function without legal basis. NSPs coverage is often low.[270]

In Kazakhstan and Uzbekistan, the government-funded NSPs exist at so-called "trust points" and "friendly units" established by the national HIV programmes in these two countries. In Kazakhstan, the government is funding NSPs as of 2008; before then, these programmes were largely funded by the Global Fund to Fight AIDS, Tuberculosis and Malaria. Trust points are established at AIDS centres and other health care facilities, and are coordinated by them. The national expert group indicates that trust points have an agreement with law enforcement agencies to avoid the latter's interference in their operations. More than 230 trust points (which include NSPs) operate in Uzbekistan; prior to 2005 they were funded by the government, and as of 2005 by the Global Fund. Most are located at AIDS Centres and other health care facilities.

In the other project countries where they exist, NSPs are NGO-based and funded by the Global Fund to Fight HIV, Tuberculosis and Malaria and other international sources. In Azerbaijan, NSPs are funded by the Global Fund and operated by the Open Society Institute and the Ministry of Health; there is no government funding. Kyrgyzstan has a decade-long history of NSPs, largely operated by NGOs, but at national level legal and regulatory framework that defines the procedures of dispensing/exchanging, collecting and disposing of needles and syringes has not yet been adopted; NGOs have adopted their own internal instructions and regulations in this regard. Most NSPs in Kyrgyzstan are funded from international sources; in some cases the government pays salaries of programme staff. In Tajikistan, establishment of NSPs is provided by the national HIV programme. NSPs are carried out in AIDS centres and in non-governmental organisations. There is no legislation or implementing acts on NSPs, as there is no funding from the government.

258 Kazakhstan's *Law "On prevention and treatment of HIV and AIDS"* [О профилактике и лечении ВИЧ-инфекции и СПИД] (5 October 1994, last amended 7 July 2006), Article 6.

259 Government of Kazakhstan, Resolution No. 468 (30 March 2000), para. 14 (List of socially significant diseases and diseases of serious hazard to others). There is also a general legal obligation of individuals to maintain their health, and the law also specifically obliges people with diseases that pose a hazard to others to follow the orders of medical professionals and health care authorities and facilities, to inform medical personnel about their disease when seeking care and to follow treatment prescribed by medical professionals and health authorities: *Law "On Health Protection"*, Articles 18-19.

260 *Law of Kazakhstan "On Health Protection"*, Article 17.

261 *Code on Administrative Offences*, Articles 326-327. In addition, the Code makes it an administrative offence to conceal the source of such an infection (if known) and the names of persons with whom they have had context (e.g., past sexual partners): Article 328.

262 Code on Public Health and the Health Care System (18 September 2009).

263 *Law of Kyrgyzstan "On HIV/AIDS"*, Article 7.

264 *Code of the Republic of Uzbekistan on Administrative Liability,* Law No. 2015-XII (22 September 1994), Articles 57 and 58.

265 See Report of the Republic of Uzbekistan, pp. 44.

266 Government of Tajikistan, "On Procedure of testing in order to identify persons infected with HIV, their registration, medical assistance to and surveillance of people living with HIV, and the list of people obliged to undergo mandatory confidential HIV testing on epidemiological indications", Resolution No. 171 (1 April 2008), Appendix 5: List of people to be mandatorily tested for HIV. See also: *Law of Tajikistan "On counteracting HIV/AIDS"*, Article 9.

267 Information provided by the national expert group of Turkmenistan [on file].

268 Azerbaijan's *Law "On HIV"*, Article 7; Ministry of Health, Order No. 157 (23 October 1997).

269 Head State Sanitary Physician of Uzbekistan, "Sanitary rules and procedures for HIV/AIDS testing and treatment for people with HIV/AIDS" [Санитарные правила и нормы по медицинскому освидетельствованию на ВИЧ/СПИД и организации медицинской помощи больным ВИЧ/СПИД], No. 0187 (6 October 2005).

270 See coverage of NSPs in table in Section 2 above.

TABLE 8: Availability and coverage of needle and syringe programmes in Central Asia and Azerbaijan (2003-2007)[271]

Country	Number of NSP sites			Number of NSP sites per 1000 injection drug users			% of injection drug users reached by NSP sites		
	2003	2005	2007	2003	2005	2007	2001/02	2005	2007
Azerbaijan	2	2	14	0.11	0.11	0.40	3.8	10 (2004)	15
Kazakhstan	129*	134*	146*	est.1	1.03	1.12	<29	29	29
Kyrgyzstan	5	17	50* (2008)	0.24	0.68	2* (2008)	8.3	< 5 (2002)	50.4* (2008)
Tajikistan	4	6	40	0.08	0.17	2.67	3	<10	est. 21-30
Turkmenistan	2	1	-	0.18	0.22	-	2.2	-	-
Uzbekistan	4	5	230	0.05	0.06	2.64	1.6	1 (2003)	

According to the national expert groups, the operation of government-funded NSPs should be improved. Often they are located in hospitals or other health care facilities, with limited hours of operation. There have been reports that clients avoid using them because of inconvenient working hours, and that people who visit them are highly visible and therefore unable to protect their confidentiality (Kazakhstan). Some expert groups (e.g., Kyrgyzstan) also noted that legislation providing for criminal liability for possessing drug residue in used syringes raises a concern because it creates a disincentive to carrying used syringes for purposes of returning them for safe disposal; it also exposes outreach workers of NSPs to potential criminal liability.

Needle and syringe programmes are staffed by social workers, health care staff and "volunteers" who often receive nominal payment. According to the expert groups, in most project countries, active and past drug users can be engaged as volunteers. For example, in Uzbekistan, people who use or have used drugs do work in outreach and as peer educators in trust points. In Kazakhstan, participation of volunteers from people who use drugs is allowed and depends on the manager of the NSP;in 2006, about 70% of all volunteers in NSPs were people who use or had used drugs. In Kyrgyzstan, in order to be employed as an outreach worker in an NSP, a person needs to be abstinent from drug use for at least 3 years. In Turkmenistan, as there are no NSPs, there is no outreach activity; however, as the national expert group stresses, the national HIV programme includes provisions on training of people who formerly used drugs as volunteer peer educators.

HIV-related care, treatment and support for people who use drugs

As noted above, antiretroviral therapy (ART) is available in all the project countries except Turkmenistan, and where it is available, it is provided free of charge to people with HIV. While this access to ART is a positive development, as noted above ART coverage generally in the project countries is very low.[272] This is particularly of concern in relation to people who use or are dependent on drugs in the project countries. Research done in 2004 showed that in the countries of Central Asia and generally in the former Soviet Union, where people who inject drugs constitute the majority of people living with HIV, people who inject drugs are nonetheless in the minority among those who receive antiretroviral therapy. According to one estimate, by the end of 2004, in Eastern Europe and Central Asia about 131,000 people needed ART but only 15,400 or 14.4% received it, of which only 2000 were active or former drug injectors. This result is striking when the proportion of HIV cases attributed to injection drug use at the time was approximately 81 % (1.08 of 1.3 million).[273] Similar results were found in an earlier 2002 study in Central and Eastern Europe and Central Asia.[274] People who inject drugs were clearly under-represented among those receiving treatment for HIV in the region, at least at that period in time. Several years later, while some progress has been made in some countries, it remains the case that people with HIV who use or are dependent on drugs continue to be disadvantaged in access to ART.

Exclusion of drug users from ART has frequently been justified by the assertion that people living with drug dependence cannot adhere to ART regimens. However, numerous studies and experience in many countries clearly show that people who use illicit drugs, including those who inject drugs, can abide by ART regimens just as well as other people living with HIV.[275] In countries of the former Soviet Union, other factors have impeded successful inclusion of drug users in ART. Instead of one comprehensive system of treatment, patients have to deal with several narrowly focused health care organisations: that is, drug dependence, tuberculosis and HIV are all treated in different facilities. Coercive drug dependence treatment, which does not include access to ART and too often does not include OST, is another barrier – both because OST has a proven record of helping drug users adhere to ART and because coercive drug dependence treatment is in itself unappealing. Drug users also face explicit or subtle discrimination and judgemental attitudes on the part of medical staff.[276] Another problem is that most facilities providing ART are situated in larger cities, which hinders access to treatment for drug users living with HIV elsewhere . People living in small towns and villages may not be able to sustain a regular commute to an AIDS centre in a larger urban centre. The national expert group from Azerbaijan also noted that health services for people who use illicit drugs are weak in general, partly because this population is so heavily marginalized.

4.2 RATIONALE FOR REFORMS

4.2.1 REFORMING NATIONAL PROGRAMMES AND LAWS ON HIV AND ON DRUGS

In each of the project countries, national programmes, strategies or plans (the names may differ) proclaim in general terms the government's policy intentions and directions in a particular area, such as HIV or illicit drugs, and sometimes determine particular actions towards these goals. As recommended by UNAIDS and OHCHR in the *International Guidelines on HIV/AIDS and Human Rights*, states "should establish an effective national framework for their response to HIV which ensures a coordinated, participatory, transparent and accountable approach, integrating HIV policy and programme responsibilities across all branches of government."[277] Furthermore, "States should ensure, through political and financial support, that community consultation occurs in all phases of HIV policy design, programme implementation and evaluation and that community organizations are enabled to carry out their activities… effectively."[278] In addition, national programmes on HIV need to include provisions to ensure the access to information, education, including communication campaigns to educate the community, so as to eradicate HIV-related stigma and to promote respect for the human rights of vulnerable groups.[279]

In addition to identifying these over-arching policy directions that should guide national programmes on HIV and on related matters (e.g., national programmes on illicit drugs), the expert groups from all of the project countries were also of the view that such directions should also be reflected in national laws — for example, by introducing explicit provisions aimed at HIV prevention among people using drugs and people in prisons.

In all countries in the region, injection drug use appears to be the single largest driver of the HIV epidemic, and there is reason for grave concern about the heightened risk of people in prisons. Yet few of the project countries' laws on HIV refer to harm reduction measures to address the health of people who use drugs, and few provide for any measures on HIV prevention and treatment in the correctional system. In many instances, other key elements of a comprehensive, effective national response to HIV are not mentioned in the national HIV law; the national expert groups generally recommend that such explicit reference should be made in the national law. Similarly, as this project has shown, even as national laws

271 The principal source of data on Table 1 is *Towards Universal Access* (2008), pp. 72-74. However, 2008 data marked with an asterisk were provided by UNODC [on file]. The number of NSP sites in Kazakhstan includes all trusts points, whether separate or as part of AIDS centres.

272 See ART coverage numbers in section 2.3 of this report.

273 C. Aceijas et al., "Antiretroviral treatment for injecting drug users in developing and transitional countries 1 year before the end of the 'Treating 3 million by 2005: Making it happen – The WHO strategy ('3 by 5'),'" *Addiction* 2006; 101: 1246-1253.

274 N. Bobrova et al., "Obstacles in provision of antiretroviral treatment to drug users in Central and Eastern Europe and Central Asia: A regional overview," *International Journal of Drug Policy* 2007; 18(5): 313-318.

275 D. Wolfe, "Paradoxes in antiretroviral treatment for injecting drug users: Access, adherence and structural barriers in Asia and the former Soviet Union," *International Journal of Drug Policy* 2007; 18(5): 246-254.

276 Ibid.

277 *International Guidelines on HIV/AIDS and Human Rights* (2006 Consolidated Version), Guideline 1.

278 Ibid., Guideline 2.

279 See *International Guidelines*, Guideline 9.

generally contain a prohibition against discrimination based on HIV status, the existing HIV laws or other regulations in the project countries often contain provisions that unjustifiably infringe human rights, such as mandatory HIV testing of a broad range of people with consequences such as denial of visa, residence or employment. Existing HIV laws also sometimes fail to ensure that important services are made available in ways that respect and promote human rights (e.g., by requiring that pre- and post-test counselling accompany HIV testing or by adequately protecting the confidentiality of patients living with HIV).

All of the project countries' national HIV laws were adopted more than a dozen years ago, between 1992 and 1996. National drug laws were adopted in 1998-1999, with the exception of Turkmenistan, where the national drug law was adopted in 2004. In the intervening years, a great deal more evidence has emerged about what measures are successful and essential for HIV prevention and treatment, including among people who use drugs and in prisons. Similarly, there is a more developed understanding of how international human rights law principles apply in the context of addressing HIV among people who use drugs and people in prison. These should inform initiatives to update the project countries' national laws, in addition to revising national programmes or strategies. This can and should extend to updating national laws on HIV, but also to updating or enacting legislation in other areas (e.g., on drug dependence treatment) that is particularly central to addressing HIV among people who use drugs.

The national expert groups pointed out that in the majority of the project countries there are no special laws on drug dependence treatment, even though the problem of drug dependence is proclaimed as a priority concern throughout the region, a concern heightened by the spread of HIV through risky drug use. The majority of the project countries follow the Russian model of drug laws,[280] focussed predominantly on prohibition of possession and trafficking of drugs, with only a few (if any) articles in the law addressing the issue of drug dependence treatment. Several of the national expert groups emphasized the need to adopt better legislation on the prevention and treatment of drug dependence. Such initiatives should revisit the current coercive approach to drug testing and drug dependence treatment (and especially for people in prison), and the use of registries of people who use or are dependent on drugs that do not adequately protect the confidentiality of patients. Responsibility for drug control and prevention of drug trafficking should be separated, including in legislation, from responsibility for drug dependence treatment, so as to avoid the current overemphasis on law enforcement and on punitive measures in relation to people who use drugs, rather than approaching drug -dependence as a medical condition. In short, police and the national Drug Control Agencies are not the appropriate bodies to advise on policies, organisation and methods of drug dependence treatment since health care of people who use drugs, is not their mandate or responsibility.

By ensuring that national programmes on HIV and drugs are based on scientific evidence and on human rights principles, the national government best orients itself, its institutions and its actions, as well as helping to orient society as a whole, towards achieving the international community's goal of "universal access" to HIV prevention, care, treatment and support.

4.2.2 FULFILING THE RIGHT TO HEALTH AND OTHER PATIENTS' RIGHTS

One of the central human rights principles of particular relevance to national programmes and laws on both HIV and on drugs is the *right to health*. States that have ratified the *International Covenant on Economic, Social and Cultural Rights* (ICESCR), recognise the right of everyone to the enjoyment of the "highest attainable standard of physical and mental health."[281] This article obliges states to take steps to achieve the full realization of this right, including measures "necessary for the prevention, treatment and control of epidemic, endemic, occupational and other diseases" and "the creation of conditions which would assure access to all medical services and medical attention in the event of sickness." In addition, Article 6 of the *International Covenant on Civil and Political Rights* (ICCPR) states that every person has the inherent right to life, which requires governments to adopt positive, pro-active measures to protect human life, including measures to reduce the spread of epidemics.[282]

280 L. Utyasheva and R. Elliott, "Effects of UN and Russian Influence on Drug Policy in Central Asia" in *At What Coast? HIV and Human Rights consequences oof the Global "War on Drugs"*, Open Society Institute, March 2009.

281 *International Covenant on Economic, Social and Cultural Rights*, 993 UNTS 3 (1966).

282 UN Human Rights Committee, *General Comment No. 6: The right to life (Art. 6)*, UN Doc. HRI/GEN1/Rev.1, 6 (1982).

The UN Committee on Economic, Social and Cultural Rights, the body of international experts tasked with monitoring states' compliance with the ICESCR, has issued a General Comment elaborating in more detail what governments need to do to realize fully the right to health.[283] According to the Committee, the following are among main responsibilities of the states under ICESCR Article 12:

- to adopt and implement a national public health strategy and plan of action, on the basis of epidemiological evidence;
- to provide essential drugs, as from time to time defined under the WHO Action Programme on Essential Drugs; and
- to ensure the *accessibility* of health facilities, goods and services on a non-discriminatory basis, especially for vulnerable or marginalized groups.

The Committee has further outlined that *accessibility* of health facilities, goods and services includes the following components:[284]

- Services are delivered without discrimination based on sex, income, national origin, physical or mental disability, social class, religion or any other grounds for non-discrimination noted in international law. The "most vulnerable or marginalized sections of the population, in law and in fact," must be particularly protected from discrimination in access to health services. States must also take special care to ensure that women and girls have equal access to health services.

- Services must be of good quality, meaning that they are "scientifically and medically appropriate." This means, among other things, that they are run by "skilled medical personnel" with scientifically approved medications, equipment and procedures. (If medical procedures that are not scientifically approved are characterized as experiments, people have a human right not to be subjected to medical experimentation without their consent.[285])

- Services must be acceptable culturally and "must be respectful of medical ethics." They must be "designed to respect confidentiality and improve the health status of those concerned." People's right to consent in a specific and informed way to medical procedures is a central principle of human rights.

- Services must be physically accessible, meaning "within safe physical reach for all sections of the population," including "vulnerable or marginalized groups," "persons with disabilities and persons with HIV/AIDS."

- Services must be economically accessible or affordable for all who need them. "Equity demands that poorer households should not be disproportionately burdened with health expenses as compared to richer households," and particular attention to affordability must be paid with respect to "socially disadvantaged groups."

Particular attention is required to ensure the health of marginalized and vulnerable groups, not only because all persons have an equal right to the highest attainable standard of health, including medical assistance provided by the state, but also as a matter of sensible policy, since the health and welfare of those on the margins of society affect the health of society as a whole. It is, therefore, necessary to ensure that there is wide and "low-threshold" access to health services, including for homeless persons without identification documents, those who are not employed, those who cannot afford medications and other supplies and those who face additional hurdles either because of their condition (e.g., drug dependence, mental illness, other disability) or attitudinal barriers (e.g., stigma surrounding their health condition, discrimination by service providers).

In addition to the right to health, other human rights must be considered and respected in the provision of health services, such as the right to privacy (and hence the corresponding duty of health workers and

283 UN Committee on Economic, Social and Cultural Rights, General Comment No. 14: The right to the highest attainable standard of health (art. 12), UN Doc. D/C.12/2000/4 (4 July 2000).

284 Ibid., para. 12.

285 ICCPR, Article 7.

facilities to preserve confidentiality), as well as the right to information, the right give informed consent to any procedures, the right to refuse or stop treatment when one wants, the right to non-discrimination at health care facilities, and the right to not be subjected to torture or other cruel, inhuman, and degrading treatment.

Box 7: The rights of patients

Everyone has the right to respect of his or her person as a human being, the right to self-determination, to physical and mental integrity and the security of person, respect for his or her privacy, such protection of health as is afforded by appropriate measures for disease prevention and health care, and to the opportunity to pursue his or her own highest attainable level of health.

Information: Information about health services and how best to use them is to be made available to the public. Patients have the right to be fully informed about their health status, including the medical facts about their condition; about the proposed medical procedures, together with the potential risks and benefits of each procedure; about alternative to the proposed procedures, including the effect of non-treatment; and about the diagnosis, prognosis and progress of treatment. Patients have the right not to be informed, at their explicit request

Consent: The informed consent of the patients is a prerequisite of any medical intervention. A patient has a right to refuse or to halt a medical intervention. The implications of refusing or halting such an intervention must be carefully explained to the patient. When a patient is unable to express his or her will and a medical intervention is urgently needed, the consent of the patient may be presumed, unless it is obvious from a previously declared expression of will that consent would be refused in the situation.

Confidentiality and Privacy: All information about a patient's health status, medical condition, diagnosis, prognosis, and treatment and all other information of personal kind must be kept confidential, even after death. Confidential information can only be disclosed if the patient gives explicit consent or if the law expressly provides for this.

Care and Treatment: Patients have the right to continuity of care, including cooperation between all health care providers and/or establishments which may be involved in their diagnosis, treatment and care. Patients have the right to relief of their suffering according to the current state of knowledge.

The enjoyment of these rights shall be secured without discrimination. In the exercise of these rights, patients shall be subjected only to such limitations as are compatible with human rights instruments and in accordance with a procedure prescribed by law.[286]

– *Declaration on the promotion of patients' rights in Europe*, adopted by the European Meeting on Patient Rights, Amsterdam, March 1994

The right to the privacy – and hence the protection of confidentiality of health information — is not only set forth in several international documents,[287] but is particularly central to realizing access to health services for marginalized and stigmatized groups, such as people with HIV or with drug dependence. Information about a patient's health status should be available only to the patient and treating health care workers. Ensuring confidentiality of information about health status and any other medical information is an important aspect of respecting human rights in terms of people who use drugs including people with drug dependence. The current legislation and/or practice in many of the project countries, of disclosing information about people receiving treatment for drug dependence or assistance in the event of overdose to law enforcement officials, violates confidentiality and, as the national expert groups have pointed out, these measures undermine trust in narcological facilities. Health services should not act as agents of law enforcement, particularly since this undermines the effective performance of their health mandate.

286 *Declaration on the Promotion of Patients' Rights in Europe*, adopted by the European Meeting on Patient Rights, Amsterdam, the Netherlands, March 1994.

287 See, for example, Article 12 of the *Universal Declaration of Human Rights*; Article 8(1) of the *European Convention on Protection of Human Rights and Basic Freedoms*; Article 17(1) of the *International Covenant on Civil and Political Rights*.

4.2.3 ENHANCING DRUG DEPENDENCE PREVENTION AND TREATMENT

The right to health and drug dependence treatment

People with drug dependence, like all people, have the right to the highest attainable standard of health goods and services, including treatment for their drug dependence. One of the first steps towards ensuring effective care is for policy-makers and health service providers to understand that drug dependence is a chronic health condition and not a result of moral deficiency or lack of will power.[288] Treatment of drug dependence should be centered in mental and physical health services that are scientifically sound, ethical and humane.

As WHO notes, it is important for policy-makers to understand that it can be very difficult for people living with drug dependence to achieve total abstinence, even when treatment is available.[289] This means that (1) policies and programmes should allow for repeated courses of drug dependence treatment for a given person, (2) governments should do everything possible to ensure availability of a variety of treatment types since a given person may need several kinds of care to be treated effectively, and (3) it must be a high priority to provide services to help people minimise the harms of drug use if they are unable to abstain.

Policy on illicit drugs in many countries is based strongly on the idea that all drug users should achieve and maintain abstinence, yet sufficient access to evidence-based and affordable treatment for drug dependence is rarely provided as part of these policies. The inadequacy of treatment for drug dependence in many countries is a serious public health problem and a missed opportunity. WHO estimates that for every US dollar spent on treatment for drug dependence, up to 12 dollars are saved because of reduced costs for health and social services, reduced crime and improved productivity of the person treated.[290]

In interpreting the content of the right to the highest attainable standard of health under the ICESCR,[291] the UN Committee on Economic, Social and Cultural Rights has articulated some principles that are pertinent to drug dependence treatment, echoing some points already noted above. Applied in the context of drug dependence treatment, these principles can be summarized as including the following:

- Services should be physically available; for drug dependence treatment, this necessarily means available in a timely way so as not to lose potential patients due to wait times, and available with sufficient variety to account for the fact that no single approach is effective for everyone.
- Services should be equally available to persons with and without criminal records.
- Services should be affordable; people should not be excluded because they cannot pay for the service.
- Informed consent for any health treatment or procedures should be the rule. Rarely will treatment without consent be ethical or justifiable in human rights terms. Compulsory medical interventions may only ever be used as a last resort.
- Confidentiality of medical information should be respected and enforced.
- Women should have access to services that address their specific needs and situations.
- Medical treatment or procedures must never rely on cruel, inhuman or degrading treatment or punishment or any form of torture.[292]

In addition, as parties to the UN international drug conventions, all of the project countries have made a commitment to "treatment, education, after-care, rehabilitation and social reintegration" of people living with drug dependence.[293] Methods of treatment for drug dependence may significantly vary depending

288 World Health Organization, Management of substance dependence (fact sheet), online; www.who.int/mip2001/files/1962/ManagementofSubstanceDependence.pdf.

289 Ibid.

290 WHO, UNODC and UNAIDS, *Substitution maintenance therapy in the management of opioid dependence and HIV/AIDS prevention: WHO/UNODC/UNAIDS position paper* (Geneva, 2004), para 44.

291 UN Committee on Economic, Social and Cultural Rights, General Comment No. 14: The right to the highest attainable standard of health, UN Doc. D/C.12/2000/4 (4 July 2000). For an interpretation of the importance of the General Comment for treatment of drug dependence, see J. Csete and R. Pearshouse, Dependent on rights: Assessing treatment of drug dependence from a human rights perspective (Toronto: Canadian HIV/AIDS Legal Network, 2007), online via www.aidslaw.ca/drugpolicy.

292 Csete & Pearshouse, *Dependent on Rights*, op cit.

293 *1961 Single Convention*, Article 38; *1971 Convention*, Article 20.

on the approach and duration of treatment. There are outpatient treatment programmes which may last for several months and more extensive programmes of staying at "therapeutic communities" or other social establishments for longer periods. The most effective forms of treatment for drug dependence combine medical treatment and psychological assistance and support.[294] Even then, some groups of people find it especially difficult to benefit from such treatment. For example, some research has found that frequently women suffering from drug dependence are unwilling to seek assistance because of fear of having their children taken away or fear of violence or other repressive behaviour from male partners.[295]

In the context of treatment for drug dependence, it is crucial to respect human rights of patients. This is important because there is a possibility of ill treatment of patients who may experience pain and psychological suffering and at the same time be unable to adequately respond to the current situation due to the withdrawal syndrome or other issues. In some countries, human rights protection organizations and other agencies have documented cases of cruel, inhuman and degrading "treatment" for drug dependence.[296] Refusal to provide other health care services until a person undergoes treatment for drug dependence has been recognized by national courts as cruel and unusual punishment.[297] International organizations have developed guidelines for drug dependence treatment, which emphasise the necessity and importance of rehabilitation, comprehensive treatment as well as opioid substitution treatment along with respect for human rights (see Box 7).[298]

Box 8: Guidelines for drug dependence treatment

There is a need for a special approach to drug dependence treatment for the following reasons:

- People with drug-related problems often have multiple treatment needs across a range of personal, social and economic areas;
- Drug abuse problems can be treated effectively if people can access treatment and rehabilitation services that are appropriate to their needs and of sufficient quality, intensity and duration;
- The financial support that underpins treatment and rehabilitation should be directed to those services that have an impact of proven efficacy;
- No one single treatment approach is effective for everyone. People may need different types of treatment, which are integrated and coordinated effectively, at different times and stages in seeking help;
- People should be able to access or be referred to the treatment that best meets their needs. Treatment services should take into account specific needs related to gender, age, health and risk behaviours;
- The prevention of blood-borne infections, including HIV and hepatitis B and C, is a key component of comprehensive treatment approach;
- Treatment services should, as far as possible, build on, link with and integrate with existing health and social agencies and provide a continuum of care. They should also include community-based support services;
- Treatment and rehabilitation services should play a key role in reducing the social stigma and discrimination against people who use drugs and supporting their reintegration into society.

UNODC, "Drug Abuse Treatment and Rehabilitation: A Practical Planning and Implementation Guide" (2003)

Cost of treatment to the patient

As noted above, realizing the right to health for people with drug dependence requires not only that good-quality services for treating that dependence be available, but that they be economically accessible as well. Since people who live with drug dependence for a significant time are often impoverished, costs to the patient constitute an important barrier to utilization of services. Ensuring access to treatment that is free-of-charge to patients is a key element of realizing universal access.

294 See European Monitoring Centre for Drugs and Drug Addiction, *Legal aspects of substitution treatment: an insight into nine EU countries*. 2003, p. 19.

295 U.S. National Institute on Drug Abuse. NIDA InfoFacts: Treatment methods for women. 1999 www.nida.nih.gov/infofacts/treatwomen.html.

296 See, for instance, Human Rights Watch. Lessons not Learned: *Human Rights Abuses and HIV/AIDS in the Russian Federation*. 2004, at: hrw.org/reports/2004/russia0404/russia0404.pdf.

297 See, for example, *Domenech* v. *Goord*, 797 N.Y.S.2d 313 (2005 N.Y. App. Div), in which denying a prisoner hepatitis C treatment until completion of drug dependence treatment amounted to cruel and unusual punishment.

298 UNODC, "*Drug Abuse Treatment and Rehabilitation: A Practical Planning and Implementation Guide*", 2003.

Compulsory drug dependence treatment

WHO and UNODC recommend that in considering the application of involuntary treatment for drug dependence, initial preference should be given to different forms of social pressure for entering treatment, rather than compulsory state-enforced admission into treatment. In any kind of involuntary treatment, special attention should be given to non-coercive means of establishing motivation in the patient to co-operate and participate in the treatment effort.[299] Many study findings show that the effect of compulsory treatment on further abstinence from drugs and level of crime rate is insignificant (whereas this effect is greater in the voluntary treatment groups).[300] Furthermore, if compulsory drug dependence treatment is to be effective, there must be:

- access to appropriate medical facilities offering good quality care;
- efforts to motivate the individual to cooperate in treatment; and
- a variety of methods applied, with the availability of rehabilitation and social networks.

Voluntary treatment should be tried first, especially in the case of people in prisons.[301] (See the section on prisons for more details of compulsory drug dependence in prisons, which is common across the project countries.) WHO recommends that any instances of compulsory treatment should be strictly regulated and their effectiveness assessed.

The ICCPR guarantees the rights to liberty, privacy and the security of the person; it also guarantees the right to be free of involuntary participation in medical experiments.[302] Therefore, compulsory treatment should be used only in extraordinary situations and in compliance with international law principles on the limitation and derogation of human rights, namely the *Siracusa Principles* adopted by the UN's member states at the Economic and Social Council in 1985. According to those principles, states may only justify necessary limitations on human rights if they are "provided for by law", are not applied in an arbitrary or discriminatory manner, and are subject to possible challenge and remedy against abusive application. Furthermore, in order to be considered to be "necessary", the state must be able to demonstrate objectively that the limitation "responds to a pressing public or social need," "pursues a legitimate aim" and "is proportionate to that aim." In addition, in applying a limitation, "a state shall use no more restrictive means than are required for the achievement of the purpose of the limitation."[303]

The United Nations has not established international standards specifically on the implementation or evaluation of drug dependence treatment. However, reflecting the approach of the *Siracusa Principles*, a 1991 UN General Assembly resolution on mental health[304] articulates some principles that are relevant to the imposition of compulsory treatment for drug dependence, including the following:

- A person's right to informed consent to undergo any medical procedure may be limited by the state only after "a fair hearing by an independent and impartial tribunal established by domestic law" (principle 1). The resolution emphasizes that this principle should apply to all patients, whether "criminal offenders" or not.
- Everyone has the right "to be treated in the least restrictive environment and with the least restrictive or intrusive treatment appropriate to the patient's health needs…." (principle 9).

299 UNODC and WHO, Principles of Drug Dependence Treatment, Discussion paper (March 2008).

300 A. Stevens et al., "The victimisation of dependent drug users: Findings from a European Study" European Journal of Criminology, 4,4 (October 2007); and A. Stevens et al., "The relationship between legal status, perceived pressure and motivation in treatment for drug dependence: Results from a European study of quasi-compulsory treatment", European Addiction Research, (2006) 12: 197-209, available at http://www.kent.ac.uk/eiss/projects/qcteurope/papers.html.

301 WHO Regional Office for Europe & Council of Europe, *Non-Voluntary Treatment of Alcohol and Drug Dependence: a European Perspective — Report of the meeting*, Moscow, Russia 22-23 April 1999.

302 *International Covenant on Civil and Political Rights*, Article 7.

303 UN Economic and Social Council, *Siracusa Principles on the Limitation and Derogation of Provisions in the International Covenant on Civil and Political Rights*, UN Doc. E/CN.4/1985/4, Annex (1985).

304 UN General Assembly, *Principles for the protection of persons with mental illness and the improvement of meant health care (resolution)*, UN Doc. A/RES/46/119 (17 December 1991).

- A person may be admitted involuntarily to a health facility only when there is "a serious likelihood of immediate or imminent harm to that person or to other persons" or when a person has "impaired judgement" that would prevent the administration of voluntary treatment (principle 16).

The General Assembly resolution also emphasizes the right to exercise informed consent for medical procedures, articulated in another way in the ICCPR as the right to security of person — that is, to control what happens to one's body.[305]

In light of these principles, in those exceptional circumstances where a person may justifiably be subjected to involuntary treatment for drug dependence, a number of protective factors should be built in, such as the following:

- persons in need of short term emergency commitment for incapacitation due to drug dependence should be immediately released from detention on completion of treatment (i.e. detoxification);
- compulsory civil commitment (for other than emergency care) is justified only when effective treatment programmes, as well as adequate and humane facilities, are available;
- the period of confinement should be limited and a person's involuntary status subject to periodic review; and
- the person concerned should be afforded certain substantive and procedural rights during the commitment proceedings (timely judicial hearing, representation by counsel, etc).[306]

In some jurisdictions, "drug treatment courts"[307] exist as a means of diverting people charged with certain (non-violent) offences from the criminal justice system when drug dependence plays some role in their offence. In some settings, in order to be eligible for this diversion, the accused person must agree to undergo court-supervised measures for treating their drug dependence. If the drug-dependent person manages to complete successfully the requirements of the treatment programme, the normal criminal sentence is not imposed. In this way, drug treatment courts attempt to reduce harm to people accused of non-violent offences by diverting people from the penal system and assisting in rehabilitation. In some drug treatment court schemes, a person charged with an offence is eligible for diversion into a drug treatment court scheme before entering a plea to the offence with which he or she is charged; in others, the person must first plead guilty to the offence to be eligible for participation in the drug treatment court. But as noted above, drug treatment courts have some serious implications for the humans rights of people undergoing them, such as the rights to presumption of innocence and due process.[308] There also have been concerns about whether the evaluations of drug treatment courts show them to be particularly effective, and whether resources are better spent on expanding access to voluntary drug dependence treatment services that are evidence-based, services for which the need often greatly exceeds the availability. While UNODC and WHO recommend that diversion of people with drug dependence into treatment should be available at every stage of the criminal justice process (with the consent of the person),[309] WHO also recommends that a wide spectrum of treatment options be available.[310] Furthermore, it should be noted that the development and improvement of the voluntary drug dependence treatment system, including accessibility, timely provision of services, affordability, and flexibility in programmes allowing them to be tailored to individual patients' needs, all further reduce the need for resorting to involuntary treatment.

Registration and reporting of people who use or are dependent on drugs

Registration of narcological patients for evaluation of the effectiveness of the treatment could be justified only under conditions of either strict confidentiality or even anonymity (in the latter case, the person's name and address are not registered). The currently used registration of people who use or are dependent on drugs constitutes a barrier to health care, including drug dependence treatment (or other care, such as HIV treatment), if people have reason to fear that in seeking treatment they face the risk that their drug-using status will be known to the police. According to the national expert groups, there are frequent breaches of confidentiality in these systems. Indeed, as noted above, in many cases the law obliges health care staff to inform law enforcement agencies about overdoses and those who seek narcological assistance, or at least to divulge such information about patients upon request by law enforcement bodies; in other cases, even if it not mandated, it is a common practice. From a public health perspective, the most serious negative consequence of drug user registration is that it pushes people who need drug dependence treatment away from it.

Such registries are also likely to be of limited use. As with other legislation in the region, the stated purpose of the registries is to protect society from drug abuse and to preserve the public health. Another goal of registration is to amass data for evaluating trends in drug use. However, as WHO suggests, registration of drug users for these purposes is useful only if the registration system captures all drug users or the great majority of them without significant biases as to those left out.[311] Where drug use (or possession of very small quantities) is criminalized and drug use and dependence are highly stigmatized, as in the project countries, it is very unlikely that the registries are representative of the drug using population in any way that could inform useful programme analysis.

Finally, while the public safety rationale behind these infringements on individual privacy may appear to be legitimate, the restrictions and consequences — including serious impediments to employment or education — are disproportionate in nature. The fact that drug-dependent people who have undergone treatment are kept on the registry for a long time (3 to 5 years in case where a person is deemed to be fully abstinent and for decades, virtually indefinitely, if relapsing), makes these consequences all the more serious, and penalises those who seek treatment.

Opioid substitution treatment (OST)

While it should be noted that opioid dependence is a complex condition and that no single treatment approach is necessarily optimal for all people, there is consistent evidence that OST is one of the most effective therapies for drug dependence.[312] OST has been recognized by WHO and many national medical associations as an effective, safe and cost-effective means of managing opioid dependence and as an essential HIV prevention measure.[313] WHO has also included methadone and buprenorphine, both used in OST as alternatives to heroin or other opium derivatives, on its Model List of Essential Medicines.[314]

OST seeks to reduce or eliminate use of illegal opioids by stabilizing people's cravings for as long as is necessary to help them avoid previous patterns of substance use and associated harms. More specifically, OST offers individuals and communities the following short-term and long-term advantages:[315]

Health benefits:

- OST helps to reduce the use of illegal opioids when administered in appropriate doses.
- OST stabilizes the cravings of people who use opioids, thus promoting improved physical and emotional well-being.
- OST provides the ability to control the quality and potency of opioid substitutes, thus mitigating the risk of overdose.
- OST reduces the risk of transmission of HIV and other blood-borne infections through sharing drug injection equipment since it is usually administered orally.

305 *International Covenant on Civil and Political Rights*, Article 9.

306 [U.S.] National Institute on Drug Abuse, *Compulsory Treatment of Drug Abuse: Research and Criminal Practice*, Research Monograph Series No. 86 (1988), p. 200, online www.drugabuse.gov/pdf/monographs/86.pdf

307 For more, see the Glossary entry in Appendix 5.

308 For more discussion, see: *Legislating for Health and Human Rights: Model Law on HIV/AIDS and Drug Use*, Module 1: Criminal Law issues, p. 29.

309 UNODC and WHO, *Principles of Drug Dependence Treatment: Discussion Paper* (March 2008), Principle 6, p. 14.

310 WHO Regional Office for Europe & Council of Europe, *Non-voluntary Treatment of Alcohol and Drug Dependence: a European Perspective*, Meeting Report, Moscow, 22-23 April 1999.

311 WHO Europe & Council of Europe, *Non-voluntary treatment of alcohol and drug dependence, supra.*

312 WHO, UNODC and UNAIDS, *Substitution maintenance therapy in the management of opioid dependence and HIV/AIDS prevention: WHO/UNODC/UNAIDS position paper* (Geneva, 2004).

313 Ibid., p. 32.

314 The Model List of Essential Medicines is meant to guide health policy-makers in knowing what medicines are necessary to ensure the health of their populations. See WHO, WHO Model List of Essential Medicines, revised March 2005 (at http://mednet3.who.int/EMLib/index.aspx). The entry states that "[b]oth buprenorphine and methadone are effective for the treatment of heroin dependence. However, methadone maintenance therapy at appropriate doses is the most effective in retaining patients in treatment and suppressing heroin use." Methadone and buprenorphine are included in that portion of the model list termed the "complementary list": this listing does not signify a partial or limited endorsement of methadone or buprenorphine, but rather indicates that this therapy should be accompanied by specialized diagnostic or monitoring facilities, or specialist medical care or specialist training.

315 For additional references regarding these documented benefits of OST, see the sources cited in Legislating for Health and Human Rights: Model Law on Drug Use and HIV/AIDS, Module 2: Treatment for drug dependence (Toronto: Canadian HIV/AIDS Legal Network, 2006), online via www.aidslaw.ca/modellaw.

- OST provides the opportunity to refer people who use drugs to other services, such as psychological support, diagnostic services, rehabilitation, HIV counselling, and other care.
- OST decreases the death rate of people who use drugs by one-third to one-quarter the rate of those people not receiving OST.
- OST more effectively retains people who are opioid-dependent in treatment than placebo and detoxification alone.
- Pregnant women and their unborn children who receive OST have fewer complications in comparison with those who do not.

Social benefits:
- OST helps reduce criminal activity associated with obtaining an illegal substance.
- OST plays an important role in community-based approaches in that the treatment can be provided on an out-patient basis, achieving high rates of retention in treatment and increasing the time and opportunity for individuals to tackle major health, psychological, family, housing, employment, financial and legal issues while in contact with treatment services.

It has sometimes been claimed that OST programmes are contrary to countries' obligations under international drug control treaties.[316] However, this is patently incorrect. In reviewing the various types of harm reduction programmes with respect to international treaties, the UN International Drug Control Programme (UNDCP), located within the UN Office on Drugs and Crime, concluded in 2002 that,

> In its more traditional approach substitution/maintenance treatment could hardly be perceived as contrary to the text or the spirit of the treaties. It is a commonly accepted addiction treatment, with several advantages and few drawbacks. Although results are mixed and dependent on many factors, its implementation along sound medical practice guidelines would not constitute a breach of treaty provisions.[317]

The International Narcotics Control Board (INCB) has acknowledged the potential of harm reduction programmes to contribute to a comprehensive drug demand reduction strategy. In its *Annual Report 2003*, the INCB recognized that "drug substitution and maintenance treatment … does not constitute any breach of treaty provisions, whatever substance may be used for such treatment in line with established national sound medical practice …. As is the case with the concept of medical use, treatment is not treaty defined."[318]

In their joint position paper, WHO, UNODC and UNAIDS underscore that the benefits of OST — including reduction of HIV and hepatitis C virus (HCV) transmission, reduction in crime, return of patients to productive routines, improved outcomes of pregnancy, and many others — far outweigh the costs.[319] They offer the following guidance for the implementation and evaluation of OST programmes:[320]

- OST may be implemented in conjunction with detoxification programmes. Detoxification alone is rarely sufficient to treat opioid dependence.
- Achieving abstinence may be the long-term objective, but it is "unfortunately not feasible for all individuals with opioid dependence, especially in the short term. An exclusive focus on achieving a drug-free state as an immediate goal for all patients may jeopardize the achievement of other important objectives such as HIV prevention."
- OST must be readily available, especially to ensure its access to opioid users at the moment when they are ready to seek treatment.
- The duration of OST should not be arbitrarily limited, as for some patients several years of treatment may be needed.

316 For example, Russian officials have repeatedly claimed that Russia's continuing criminal prohibition of methadone is required by the UN drug control conventions, even though such a claim is demonstrably false and many other countries who are also parties to the same treaties have made OST available for many years.

317 UNODC (UN Drug Control Program), *Flexibility of treaty provisions as regards harm reduction approaches*, Decision 74/10, E/INCB/2002/W.13/SS.5 (30 September 2002), para. 17.

318 INCB, *Report for the International Narcotics Control Board 2003*, E/INCB/2003/1, Part II, p. 37.

319 WHO, UNODC and UNAIDS, Substitution maintenance therapy in the management of opioid dependence and HIV/AIDS prevention, op. cit., paras. 68-69.

320 Ibid., paras. 14-19, 26, 41, 50-51.

- Countries should ideally provide several forms of OST since no single approach to treatment is likely to succeed for everyone.
- The therapeutic dose of the substitute opioid medicine should be based on a medical assessment of each patient; dosage should not be linked to punishment or reward. A patient should not be refused OST on the grounds that s/he continues to take illicit narcotic drugs. Consumption of illicit narcotic drugs should not by itself indicate mandatory discharge from treatment. Those who are unable or unwilling to stop taking illicit narcotics should undergo treatment to decrease the level of morbidity, disability, and mortality caused by or related to drug abuse. In these cases opioid substitution treatment helps these people to, at least, stabilize their use of illicit drugs, if not stop the use.
- Where opioid dependence is widespread, OST should be provided not only in specialized hospitals but also in general primary health care and social service facilities. The most effective programmes are integrated with other health services, including HIV and AIDS care, treatment and prevention.
- In addition, in order for women with opioid dependence to benefit from treatment services, these need to be available in settings and under circumstances where they can be with their children.[321]

Management of overdose

As noted above, naloxone has been shown to be effective in preventing opioid overdoses from being fatal, if administered in time. Experience from some countries has shown it is possible to make this intervention available not just from health facilities and practitioners, but also via outreach workers and peers who are more likely to be present when an overdose occurs and able to intervene more quickly. Given the significant role of overdose in causing death among people with drug dependence, the project countries should explore how best to make sure naloxone is available.

Also of urgent concern is the requirement in virtually all of the project countries that cases of overdose treated by government health facilities be reported to the police as a matter of law. This practice leads to people not disclosing incidents of overdose to health care facilities and not calling for emergency medical help out of fear of prosecution. The national expert groups from Uzbekistan and Azerbaijan recommend that this practice be abolished immediately; this recommendation is applicable for all the project countries.

4.2.4 IMPROVING ACCESS TO HIV PREVENTION AND TREATMENT

HIV testing and counselling

All UN member states have made commitments to ensure access for all people to HIV testing and treatment, care and support for people living with HIV. The unanimous *Declaration of Commitment on HIV/AIDS* of the UN General Assembly in 2001 was a pledge by all governments, among other obligations, to work toward access for all people to voluntary and confidential HIV testing with counselling and treatment for HIV-related health disorders for all who need it.[322] In the declaration from a follow-up General Assembly meeting in 2006, states reaffirmed their commitment to the goal of universal access to HIV testing and treatment, though the timeline for those commitments was not stated.[323]

In the *International Guidelines on HIV/AIDS and Human Rights*, UNAIDS and OHCHR recommend that countries enact legislation to ensure that HIV testing will be performed only with person's informed and voluntary consent — project countries' legislation requires revision in several respects to implement this recommendation. UN agencies have developed several sets of standards for HIV testing with attention to human rights protections of people being tested.[324] In all their guidelines, WHO and UNAIDS underscore the importance of human rights protections related to HIV testing.[325] In particular:

- HIV testing should be voluntary. People have the right not to be forced or compelled in any way to be tested for HIV. As noted above, this principle derives from the human right to security of person.

321 UNODC, *Substance abuse treatment and care for women: Case studies and lessons learned* (Vienna: UNODC, 2004), p. 20.

322 UN General Assembly, *Declaration of Commitment on HIV/AIDS*, UN DOC. No. A/RES/S-26/2 (2001), paras. 52, 55.

323 UN General Assembly, *Political Declaration on HIV/AIDS*, UN DOC. No. A/RES/60/262 (2 June 2006).

324 UNAIDS and WHO, *UNAIDS/WHO Policy Statement on HIV Testing* (Geneva, 2004) and WHO and UNAIDS. *Guidance on Provider-Initiated HIV Testing and Counselling in Health Facilities* (Geneva, 2007).

325 E.g., see WHO Regional Office for Europe, "HIV/AIDS Treatment and Care: WHO Protocols for CIS Countries" (Copenhagen, 2004).

- People should not be tested for HIV without giving their informed consent to be tested. This means that they need to be given certain information about HIV and the HIV test before they can be expected to consent to or reject the test. (See Box 9.)
- Results of an HIV test and the fact of seeking an HIV test should be confidential information, not shared beyond the testing facility. As noted above, confidentiality of medical procedures and medical information derives from the human right to privacy.
- People should have the opportunity to receive counselling about HIV, including the chance to ask questions of a trained counsellor in a private setting. HIV infection is a health condition that is related to sex and illicit drug use, which are sensitive topics in many cultures. Counselling linked to HIV testing may be the best way for many people, including criminalised and socially marginalized people, to get clear information about HIV.

Consent, confidentiality and counselling are sometimes referred to as "the three C's" of HIV testing, representing important human rights protections for people seeking and undergoing this procedure.

Box 9: What constitutes enough information for informed consent to HIV testing?

The 2007 WHO/UNAIDS *Guidance on Provider-Initiated HIV Testing and Counselling in Health Facilities* recommends that in many circumstances, doctors, nurses and other health professionals should offer an HIV test to patients who present at their facilities rather than waiting for the patient to request a test. Nonetheless, even if the test is initiated by the health-care provider, the person to be tested has the right to receive the information noted below and to consent to or reject the test. Unlike the 2004 UNAIDS/WHO HIV testing policy, the 2007 guidance states that this information can be provided in a group setting, though the act of consenting to the test should be private and in the presence of a health professional. Pre-test information should include:

- Why testing and counselling are being recommended;
- Benefits of HIV testing and potential risks of testing, such as discrimination, abandonment or violence;
- Health services and other support that are available to persons following an HIV test, including what kind of treatment is available for people living with HIV;
- Assurance that the test result will be treated confidentially;
- The fact that the patient has the right to decline the test (but WHO and UNAIDS recommend that an HIV test be administered unless the patient explicitly declines a health professional's offer of a test);
- The fact that declining an HIV test will not affect the patient's access to services that do not depend on knowledge of HIV status; and
- In the event of a positive test result, encouragement to the patient to disclose his or her status to others who may be at risk of exposure to HIV.

The 2007 guidance further recommends that there be an opportunity for patients to ask questions of a health professional; it is not specified whether asking questions should happen in a group or in private.

WHO/UNAIDS, *Guidance on Provider-Initiated HIV Testing and Counselling in Health Facilities* (2007)

Given its forced nature, involuntary HIV testing violates the rights to liberty, privacy and security of the person.[326] Furthermore, this coercive measure is sometimes used with regard to groups least able to protect themselves because they are within the ambit of government institutions or the criminal law, such as soldiers, prisoners, sex workers, men who have sex with men and people who use illegal drugs. However, testing of certain population groups based on their identity violates the non-discrimination principle. The *International Guidelines on HIV/AIDS and Human Rights* recommend that public health, criminal and anti-discrimination legislation should prohibit involuntary HIV testing of targeted groups, including criminalized persons such as drug users.[327] They also note that any exception to voluntary testing requires specific judicial authorization based on a rigorous evaluation of whether such a violation of liberty, privacy and security of person would be justified,[328] in accordance with the *Siracusa Principles* already noted above. UNAIDS and WHO have rejected involuntary HIV testing on public health grounds, noting that "voluntary testing is more likely to bring about behavioural changes to avoid HIV transmission to other people".[329] In addition, involuntary testing may undermine HIV prevention efforts in the following respects:

- It may add to stigmatization of and discrimination against people living with and vulnerable to HIV and drive them away from health services. Consequently, those who are most susceptible to HIV may fail to be tested.
- It reduces confidence of patients in health services; it is important for health service providers to establish good relationships with people living with or vulnerable to HIV, who are likely to need health services over a long period.
- Mandatory testing may create a false sense of security among people not subjected to it, who may then eschew safer sex and other behaviours to protect themselves from infection.
- Mandatory testing programmes are expensive, drawing funds away from more effective prevention programmes.[330]

According to OHCHR, UNAIDS and UNDP, the only circumstance for mandating HIV testing, is in the case of people donating blood, organs, tissue or other bodily substance, where there is an obvious public health imperative to perform HIV testing, and a legal duty of care towards potential recipients who need to give fully informed consent to the donation.[331] As stated in the *International Guidelines*: "the interest in public health does not justify mandatory HIV testing or registration, except in cases of blood/organ/tissue donations, where the human product rather than the person, is tested before use on another person".[332] However, it is still important that potential donors be aware of the public health justification for requiring the test and should have the opportunity to give informed consent to an HIV test.

- It should be evident that imposing mandatory HIV testing or the punitive application of compulsory HIV testing poses a serious public health and human rights challenge. A number of policies and practices currently in place in the project countries require reform. A policy of involuntary testing of people whom health officials have reason to believe might be HIV-positive — as is done in some of the project countries — invites abuse and reinforces stigma against people who are vulnerable to the infection. Coercive HIV testing of people living with drug dependence can only be counterproductive, discouraging people who are already fearful and criminalised from seeking the health services they need. The same is true of sex workers and people who are homeless. Thus, charging with criminal or administrative offences those who refuse to undergo treatment or who refuse to identify sexual partners is a self-defeating policy that inevitably discourages people from seeking HIV testing and other care. Years of human rights-based practice in other countries have demonstrated that even the most socially marginalized people will consent to HIV testing if it is offered in respectful ways, undertaken with strict confidentiality, and linked to information, treatment and support. Meeting these standards should be the goal in the project countries, as in all countries.

- Many countries have adopted policies of *offering* HIV tests to all pregnant women, but those offers must be made with an opportunity for informed consent to, or rejection of, the test, including an explanation of mother-to-child transmission of HIV and how it can be prevented. WHO and UNAIDS have repeatedly stated that involuntary testing is not justified for pregnant women. Practices of making HIV testing routine that do not ensure that women are able to give, and give, informed consent to HIV testing infringe human rights.

326 *International Guidelines on HIV/AIDS and Human Rights*, para. 135.

327 Ibid., para. 22(j).

328 Ibid., paras. 20 (b).

329 *UNAIDS/WHO Policy Statement on HIV Testing* (June 2004).

330 WHO, *Statement from the Consultation on Testing and Counseling for HIV Infection* (1992), at 3-4.

331 *Taking action against HIV: Handbook for Parliamentarians* (2007), p. 79.

332 *International Guidelines*, para. 120.

- As noted below (see section below on prisons), compulsory testing of prisoners is not recommended by UNODC, WHO or UNAIDS and not justified on public health grounds. Prisoners do not lose their right to consent to medical procedures just because they are in state custody.

- According to the *International Guidelines on HIV/AIDS and Human Rights*, mandatory pre-marital testing and/or requirement of "AIDS-free certificates" as a precondition for the grant of marriage licences under state laws is a violation of the right of people living with HIV to "marry and to found a family" and their equal rights within marriage.[333] A similar conclusion was reached by the national expert group of Uzbekistan, where there is mandatory pre-marital testing for HIV, drug use, alcohol dependence, mental disorders, STIs and a number of other diseases.[334] According to the expert group, this, in turn, limits opportunities for provision of health care services for women and increases risk of children born with HIV infection; "moreover, issues of providing pre-test counselling of these people have not been resolved and confidentiality is not guaranteed after receiving test results."

- Imposing mandatory HIV testing on foreigners is not warranted. The *International Guidelines on HIV/AIDS and Human Rights* advise that "there is no public health rationale for restricting liberty of movement or choice of residence on the grounds of HIV status. According to current international regulations, the only disease which requires a certificate for international travel is yellow fever. Therefore, any restrictions on these rights based on suspected or real HIV status alone, including HIV screening of international travelers, are discriminatory and cannot be justified by public health concerns".[335] The *International Guidelines* point out that "where states prohibit people living with HIV from longer-term residency due to concerns about economic costs, States should not single out HIV infection , as opposed to other comparable conditions, for such treatment and should establish that such cost would indeed be incurred in the case of the individual alien seeking residency. In considering entry applications, humanitarian concerns, such as family reunification and the need for asylum, should outweigh economic considerations".[336]

- Finally, attempts to exclude people living with HIV from the workforce are unfair and a breach of human rights. Therefore, requiring people to be tested for HIV as a condition of employment is a practice that should be abolished, according to the *International Guidelines on HIV/AIDS and Human Rights*: "laws, regulations and collective agreements should be enacted so as to guarantee… freedom from HIV screening for employment, promotion, training or benefits".[337] Mandatory HIV testing in the employment context is also short-sighted in that it can arbitrarily exclude the most qualified person from a position and create an unnecessary burden on the social security system. Laws should be reviewed to ensure that they contain "prohibition of HIV screening for employment, promotion, or training purposes."[338] The International Labour Organization's *Code of Practice on HIV/AIDS and the World of Work* contains key principles for policy development in the area of HIV prevention, management, care and support of workers, designed for politicians, employers, employees, and others: among other measures, it recommends prohibit HIV screening aimed to exclude people living with HIV from employment sector.[339] In the health professions, rather than trying to exclude health workers living with HIV, WHO has long recommended the practice of "universal precautions" — that is, the routine use of gloves, goggles and other protective wear by health workers on the assumption that the blood and other bodily fluids of any patient or other worker could be infected with HIV or other infectious pathogens.[340] People in military service also have the right to consent to medical procedures, and they should not be denied the opportunity to work in the military simply because they are HIV-positive.

333 *Universal Declaration of Human Rights*, Article 16; UNAIDS/OHCHR, *International Guidelines on HIV/AIDS and Human Rights*, paragraph 118.

334 Republic of Uzbekistan, Resolution "*On Medical Examination of Persons Entering Marriage*", Resolution No. 365 (25 August 2003).

335 *International Guidelines on HIV/AIDS and Human Rights*, paras 127.

336 Ibid, para 128.

337 *International Guidelines on HIV/AIDS and Human Rights,* Guideline 5, para 22(d)(ii).

338 *Taking action against HIV: Handbook for Parliamentarians*, p. 77.

339 International Labour Organization, *Code of Practice on HIV/AIDS and the World of Work* (Geneva, 2001), key principle 4(6), p. 4 and pp. 14-15.

340 UNAIDS, "Universal precautions and blood safety" (July 2008), online: http://www.unaids.org/en/PolicyAndPractice/Prevention/UnivPrecaution/default.asp.

Increasing access to HIV prevention for people who use drugs: NSPs and outreach

A primary focus of HIV prevention efforts among people who use drugs is reducing the risk of HIV transmission through sharing of drug injection equipment. UN agencies recognize the importance of such *harm reduction* policies and programmes in the maintenance of public health — meaning policies or programmes that aim to reduce the harms associated with drug use, but do not necessarily require complete abstinence from drug use. As articulated by UNODC, the concept of harm reduction encompasses "a variety of approaches to reducing the damage caused by drug abuse to individual and collective health, social and economic welfare".[341]

Box 10: HIV prevention, treatment and care among people who use drugs[342]

WHO, UNAIDS and UNODC have developed a comprehensive package of interventions for prevention, treatment and care of HIV in injecting drug users, which are based on scientific evidence, and should include:

I. Needle and syringe programmes;
II. Opioid substitution therapy and other drug dependence treatment;
III. Voluntary HIV testing and counselling;
IV. HIV treatment and care, including antiretroviral therapy;
V. Prevention and treatment of sexually transmitted infections;
VI. Condom programming for injecting drug users and their sexual partners;
VII. Targeted information, education and communication for injecting drug users and their sexual partners;
VIII. Hepatitis (B and C) diagnosis, treatment and vaccination where appropriate; and
IX. TB prevention, diagnosis and treatment.

Extensive evidence demonstrates that harm reduction measures (such as access to sterile injecting equipment and opioid substitution therapy) are feasible, effective as public health measures, cost-effective, and do not lead to increased drug use.[343] The implementation of these measures is not only permissible under the international drug control treaties according to UNODC,[344] but is also consistent with (and arguably required by) States obligations under the international law of human rights – and in particular, the obligation to take positive measures to protect and promote the highest attainable standard of health, with a particular emphasis on the health of those who are marginalized.[345]

Programmes that offer sterile syringes and other equipment for injection to people using drugs are a critical component in efforts to prevent HIV infection and other blood-borne diseases as well as an important approach for reducing other risks related to the use of injection narcotic drugs. Needle and syringe programmes (NSPs) have been endorsed by a wide range of scientific and medical organizations, as well as by UNAIDS, WHO and UNODC.[346] The UN General Assembly's *Declaration of Commitment on HIV/AIDS* in 2001 recognizes the importance of ensuring "increased availability of and non-discriminatory access to, inter alia, …. sterile injecting equipment", and calls for the accessibility of sterile injecting equipment as an important preventive measure in reducing the transmission of HIV.[347] UNODC has stated that "there is some evidence to suggest that the availability and regular use of clean injecting equipment can prevent, halt and perhaps even reverse HIV/AIDS epidemics among injecting drug users".[348] UNAIDS underlines

341 UNDCP (Legal Affairs Section), *Flexibility of treaty provisions as regards harm reduction approaches*, Decision 74/10, UN Doc. E/INCB/2002/W.13/SS.5, 75 session, Vienna, 30 September 2002.

342 WHO/UNODC/UNAIDS, *Technical Guide for countries to Set Targets for Universal Access to HIV prevention, treatment and care for injecting drug users* (Geneva, 2009).

343 Opioid substitution treatment, which is often considered as a harm reduction measure, has been discussed in the section above regarding drug dependence treatment. Harm reduction programs in prisons are discussed in the section below about prisons. In this section, we focus on the critical harm reduction intervention of needle and syringe programs (NSPs).

344 UNDCP (Legal Affairs Section), *Flexibility of treaty provisions as regards harm reduction approaches*, op cit.

345 *Taking action against HIV: A Handbook for Parliamentarians* (2007), p. 175.

346 UN General Assembly, *Declaration of Commitment on HIV/AIDS*, UNGA Resolution S-26/2 (27 June 2001); UNDCP (Legal Affairs Section), *Flexibility of treaty provisions as regards harm reduction approaches*, Decision 74/10, UN Doc. E/INCB/2002/W.13/SS.5 (2002).

347 *Declaration of Commitment on HIV/AIDS,* paras 23 and 52.

348 UNODC, World Drug Report 2004, s 1.3.3 p. 52. at: www.unodc.org/pdf/WDR_2004/Chap1_injecting_drugs.pdf.

that "harm reduction measures such as access to sterile injection equipment; drug dependence treatment such as methadone and buprenorphine; community-based outreach; and providing HIV prevention information are among the most effective and cost-effective measures to prevent the epidemic among injecting drug users."[349] In the *International Guidelines on HIV/AIDS and Human Rights*, OHCHR and UNAIDS recommend to States that: "restrictions on the availability of preventive measures, such as condoms, bleach, clean needles and syringes, should be repealed. Widespread availability of these preventive measures through various means, including vending machines in appropriate locations, should be considered… "[350] They also further recommend that: "Criminal law should not be an impediment to measures taken by States to reduce the risk of HIV transmission among injecting drug users and to provide HIV-related care and treatment for injecting drug users. Criminal law should be reviewed to consider: a) the authorization or legalization and promotion of needles and syringe exchange/distribution programmes; and b) the repeal of laws criminalizing the possession, distribution and dispensing of needles and syringes".[351]

It is important to note that sterile needle programmes may entail a "one-for-one" exchange or exchange of "one-for-one plus extra" syringes based on the needs of the client. Research has suggested that people who use syringe *distribution* programmes tend to reuse syringes less than clients of programmes that enforce a strict policy of "one-for-one" *exchange*. Needle distribution is more effective in reducing risk behaviour by people who inject drugs.[352]

Along with exchange and distribution of needles, sterile needle and syringe programmes may also provide: (a) other related material for safer injection drug use, including sterile water ampoules, swabs, filters, safe acid preparations, spoons and bowls and other appropriate materials; (b) materials to enable safer smoking and inhalation of drugs, such as pipes or stems; and (c) condoms and other safer sex materials; d) first aid in emergency situations.[353] Provision of these supplies as a supplement to sterile syringes may also encourage the use of sterile syringe programmes in general, thus reinforcing their harm reduction benefits. The provision of sterile smoking equipment such as pipes and ampoules reduces the likelihood of transmission of infections, such as hepatitis C, via unclean equipment.[354]

Box 11: Potential legal barriers to effective NSPs

Possible legal barriers to effective functioning of sterile syringe programmes include:

- The operation of sterile syringe programmes can be apparently at odds with legal provisions that criminalise "*facilitation*" of or "*incitement*" to drug use, and can cause collision between law enforcement and health services.

- Liability for possession of drug use paraphernalia: WHO has recognized that legislation that penalizes people who inject drugs for possession of sterile injecting equipment, as well as legislation that penalizes health workers who make such equipment available, "can be an important barrier to HIV control among injecting drug users".[355]

The law may *criminalise the personal use or consumption* (as well as *possession*) of illegal drugs and the *possession of trace amounts of illegal drugs* that are often present as residue in syringes that have been used to inject drugs. In some legal systems, possession of trace amounts in syringes may constitute grounds for criminalisation. The criminalisation of possession of trace amounts of illegal drugs is a concern for sterile syringe programme clients, who may be reluctant to return or safely dispose of syringes that contain residue from injection, and are thus put in a position of having to reuse syringes. The *Handbook for Legislators on HIV/AIDS, Law and Human Rights* recommends exempting from criminal liability the possession of trace amounts of illegal drugs.[356]

Studies have shown that laws criminalizing syringe possession act as a disincentive for people to possess sterile injecting equipment, result in an increase in high-risk activities, such as syringe sharing and reuse, and may also lead people who inject drugs to dispose of syringes unsafely.[357] High risk activities decrease in the legal systems, where access to syringes is made easy and affordable.[358]

The location of sterile syringe exchange programmes is crucial for their effectiveness. These programmes should be easily accessible. Effective implementation of syringe exchange programmes may also be undermined by formal or informal presence of law enforcement agencies in the vicinity of the exchange programmes or pharmacies.[359] Numerous studies and reports have identified police interaction with people who use injection drugs as limiting the efficacy of sterile syringe programmes and as creating an additional risk factor for HIV transmission.[360] Thus, effective operation of needle exchange programmes often depends on cooperation between law enforcement agencies and health authorities, staff and clients involved in the programme, especially in jurisdictions where possession of trace amounts of drugs or syringes remain prohibited.[361] Often, such coordination will include training (e.g., to ensure that police are aware of the importance of NSPs and that the law should not be applied in ways that impede their use) and agreements between law enforcement officials and syringe programme providers on policing practices in areas surrounding sterile syringe programme sites.[362] Alternatively, protocols of law enforcement agencies can prohibit searches and seizures for the purpose of drug-related offences conducted near sterile syringe programme locations or pharmacies where people may purchase sterile syringes.[363]

More generally, a lack of confidentiality (or perceived lack of confidentiality) in the operation of NSPs may result in decreased use of such programmes by clients fearing repercussions of their health information being shared,[364] including discrimination, and other social and institutional violations of their human rights.[365]

Box 12: Supervised drug consumption facilities

In addition to the other harm reduction interventions noted here, states may consider the implementation of supervised drug consumption facilities (SDCFs) based on an assessment of local needs.

Such facilities (also called "safe injection sites" when their focus is on reaching injection drug users) are legally sanctioned health and social welfare facilities that enable the consumption of pre-obtained drugs with sterile equipment under supervision of health professionals.[366] Supervised drug consump-

349 UNAIDS, *Practical Guidelines for Intensifying HIV Prevention: Towards Universal Access*, 2007, p. 46.

350 *International Guidelines on HIV/AIDS and Human Rights*, Guideline 6, para. 39.

351 Ibid, Guideline 4, para. 21(d).

352 A. Kral et al, "Injection risk behavious among clients of syringe exchange programs with different syringe dispansation policies", Journal of Acquired Immune Deficiency Syndromes 37(2) (2004): 1307-1312.

353 *Legislating for Health and Human Rights: Model Law on Drug Use and HIV/AIDS*, Canadian HIV/AIDS Legal Network, Module 3: Sterile syringe programs.

354 Studies have identified crack smoking as a possible risk factor for HIV, hepatitis C and tuberculosis; infectious diseases may be transmitted via the sharing of implements through which contaminated blood particles are transmitted. See A.E. Weber et al, "Risk factors associated with HIV infection among young gay and bisexual men in Canada", *Journal of Aquired Immune Deficiency Syndromes* 2001; 28: S1-S8; J.McMahon and S.Tortu, "A potential hidden source of hepaitis C infection among noninjecting drug users," *Journal of Psychoactive Drugs* 2003; 35: 523-534.

355 WHO *Policy Brief: Provision of Sterile Injecting Equipment to Reduce HIV Transmission*, p. 2.

356 UNAIDS, Inter-parliamentary Union, Handbook for Legislators on HIV/AIDS, Law and Human Rights, 1999, p. 54, online: www.ipu.org/PDF/publications/aids_en.pdf.

357 R. Bluthenthal et al, "Drug paraphernalia laws and injection-related infectious disease risk among drug injectors," *Journal of Drug Issues* 1999; 29(1): 1–16; W. Small et al, "Impacts of intensifyed police activity on injection drug users: evidence from an ethnographic investigation," *International Journal of Drug Policy* 2006; 1: 89-95.

358 See D.A. Calsyn et al, "Needle use practices among intravenous drug users in an area where needle purchase is legal," *AIDS* 1991; 5(2): 187-193.

359 E. Wood et al., "The impact of a police presence on access to needle exchange programs," *Journal of Acquired Immune Deficiency Syndromes* 34,1 (2003):116-117; W. Small et al., "Impact of intensified police activity on injection drug users: Evidence from an ethnographic investigation," *International Journal of Drug Policy* 17 (2006):85-95; H. Cooper et al., "The impact of a police drug crackdown on drug injectors' ability to practice harm reduction: A qualitative study," *Social Science and Medicine* 61 (2004)5) 673-684.

360 Ibid.

361 Legislating for Health and Human Rights: Model Law on Drug Use and HIV/AIDS (Toronto: Canadian HIV/AIDS Legal Network, 2006), Module 3: Sterile syringe programs, p.23, online via www.aidslaw.ca/modellaw.

362 Appropriate police liaisons and training are recommended in the *Handbook on HIV/AIDS, Law and Human Rights*, p. 54.

363 *Legislating for Health and Human Rights: Model Law on Drug use and HIV/AIDS*, Module 3: Sterile syringe programs, p.23.

364 Police interference has been identified as an important barrier to clients' use of needle exchange programs. T. Rhodes et al, "Situation factors influencing drug injecting, risk reduction snd syringe exchange in Togliatti City, Russian Federation : a qualitative study of micro risk environment," *Social Science and Medinice* 57, 1 (2003): 39-54.

365 Artcile 17.1 of the International Covenant on Civil and Political Rights and Article 12 of the Universal Declaration of Human Rights contain a prohibition on "unlawful" interference with a person's right to privacy.

366 K. Dolan, "Drug consumption facilities in Europe and the establishment of supervised injecting centres in Australia," *Drug and Alcohol Review* 2000; 19: 337–346; W. Schneider, *Guidelines for the Operation and Use of Consumption Rooms* (materialien Nr.4), Akzept e. V and C von Ossietzky Universitat Oldenburg, 2000.

tion facilities have been established in response to the escalating epidemics of HIV infection and hepatitis C among people who use drugs, connected with the fact that large numbers of people who use drugs were not being reached by existing services, and the health and public order challenges associated with the use of illegal drugs, especially in public places. SDCFs constitute a specialized health intervention within a wider network of services for people who use drugs.

By providing a facility that other services cannot offer, SDCFs play an important role in establishing and maintaining contact with high-risk groups of people using drugs, particularly people who inject drugs in public, who tend to be characterized by social exclusion, poor health and homelessness, and who often lack access to health care services. People who use drugs in public areas are also more vulnerable to public hostility and intensive law enforcement that may increase the harms related to drug use.

SDCFs aim to reduce the risk of transmission of blood-borne infections, in particular HIV and hepatitis; to reduce the likelihood of illness and death resulting from overdose; and to help people who use drugs avoid other harms associated with drug consumption under unhygienic or unsafe conditions. At the community level, SDCFs seek to address public order and safety concerns associated with public drug use.[367] As is the case with NSPs, extensive studies have found that SDCFs do not lead to increased drug use or public disorder, but rather provide benefits to the health of individuals who use them and to communities experiencing public disorder with open drug-use scenes.

Health services provided by primary health care facilities cannot always cover a large number of people using drugs since these people are often marginalized and fear prosecution on the part of authorities. A key complement to NSPs is outreach efforts to ensure that marginalized populations come into contact with these (and other) health services. Outreach work is useful in identifying networks of people who use drugs, introducing them to the harm reduction services, building trust between programme staff and people who use drugs, and distributing sterile injection equipment and educational materials.[368] These programmes also provide referrals for drug dependence treatment and to other health facilities (including HIV testing and counselling); they can also provide social assistance (including legal assistance).[369] In some places, outreach workers are instructed how to use opioid antagonists such as naloxone for quick neutralization of the effect of opiate overdose in emergency situations.

Such outreach work with people who use drugs can be carried out by both professional health workers and by people who themselves belong to the population ("peers"). Research confirmed that outreach work done by people from among drug users is more effective than that done by social or health workers.[370] Peer work can more effectively involve and inform people who use drugs, since the latter are likely to respect those who have experience of drug use. In particular, programmes staffed by these people are very effective in reaching people who do not have access to other sources of sterile syringes, such as pharmacies. Therefore, in addition to respecting human rights, it makes good programmatic sense that NSP workers (including outreach workers) should not be discriminated against on the basis of using illicit drugs currently or in the past.

Outreach programmes that provide information and educate people using injection narcotic drugs complies with international agreements on drugs. None of the UN drug control conventions contain provisions that prohibit disseminating information relating to drug use with the goal of reducing the associated harms. Nevertheless, in some legal systems outreach workers may face a risk of prosecution for "encouraging" or "inciting" or "facilitating" drug use by providing information regarding safe drug consumption practices. Outreach programmes dispensing sterile syringes and other supplies reducing harm from unsafe drug use practices may become vulnerable in the face of laws prohibiting possession or distribution

367 Legislating for Health and Human Rights: Model law on drug use and HIV/AIDS, Module 4: Supervised drug consumption facilities (Canadian HIV/AIDS Legal Network, 2006), online www.aidslaw.ca/modellaw.

368 Legislating for Health and Human Rights: Model law on drug use and HIV/AIDS, Module 6: Outreach and information (Canadian HIV/AIDS Legal Networ, 2006), online www.aidslaw.ca/modellaw.

369 Other examples of social assistance may include training, help with housing issues, counseling on financial matters, support from social workers, participation in mutual support groups.

370 R.H. Needle et al, Evidence for action: effectiveness of community-based outreach in preventing HIV/AIDS among injecting drug users, WHO, 2004. Available via www.who.int/hiv/pub/idu/en. Studies show that peer influence, in contrast to safe drug use eductaion alone, can lead to significant reductions in high-risk behaviour, such as needle sharing, by people who inject drugs: e.g., see H. Madray and Y. van Hulst, "Reducing HIV/AIDS high risk behaviour among injection drug users: peers vs. education", Journal of Drug Education 2000; 30(2): 205-211. Peer-run organisations may be able to access and provide harm reduction measures to high-risk communities not accessible to other harm reduction services: e.g., see E. Wood et al, "An external evaluation of a peer-run 'unsanctioned' syringe exchange program," Journal of Urban Health 2003; 80(3): 455-464.

of "drug paraphernalia". To ensure effective reduction of risk caused by illicit drug use, national legislation should exempt harm reduction programmes and outreach workers from criminal liability.

Towards effective HIV care, treatment and support

The right to be treated for HIV infection is part of the human right to enjoy the highest attainable standard of health goods and services guaranteed in the ICESCR. Resolutions of the UN Commission on Human Rights (now succeeded by the Human Rights Council) have articulated the specific right of people living with HIV to the medical care and treatment they need and called upon countries to do everything possible to ensure "accessibility and affordability for all without discrimination, including the most vulnerable or socially disadvantaged groups of the population, of pharmaceutical products or medical technologies used to treat pandemics such as HIV/AIDS…".[371] These statements from a multilateral human rights body were significant in that it was accepted by many policy-makers and health experts for many years that low-income people or people in low-income countries would simply not be able to be treated for HIV infection because of the high cost of antiretroviral medicines.

The *International Guidelines on HIV/AIDS and Human Rights* urge states to take "measures necessary to ensure for all persons, on a sustained and equal basis, the availability and accessibility of quality goods, services and information for HIV/AIDS prevention, treatment, care and support, including antiretroviral and other safe and effective medicines…".[372] The Guidelines note further in this regard that states should take "positive measures" to address barriers to treatment access for vulnerable persons, including people who use illegal drugs.[373] As noted above, the UN General Assembly's *Political Declaration on HIV/AIDS* in 2006 reiterated member states' commitment to universal access to HIV/AIDS treatment, care and support. Dramatic reductions in the price of first-line antiretroviral medicines in many countries since 2001 have made these commitments more realizable, though there remain many barriers to universal access to treatment. The World Health Organization has issued many guidelines to countries on best practices in treatment of HIV infection and opportunistic infections, emphasizing the importance of non-discriminatory access to treatment,[374] and national HIV authorities in most countries have published guidelines for local practitioners.

As reflected in the national expert groups' reports, improving provision of antiretroviral treatment to persons with HIV infection who require this treatment must be a priority, since it extends their lives and ability to work, decreases viral load and hence the risk of transmission to others, and motivates the people to know their HIV status. All of the project countries have national policies and sometimes laws that guarantee people living with HIV access to treatment and care, but these policies are meaningless if people who use drugs are indirectly excluded from this treatment because of the criminalisation and marginalization they face. Hence legal reforms to reduce this criminalisation and marginalization are important as part of the effort to ensure universal access to treatment. In addition, the administrative and logistical walls between drug dependence treatment and HIV treatment are a clear impediment to making care in both domains as patient-friendly as possible.

4.3 RECOMMENDATIONS FOR POLICY AND LEGISLATIVE REFORM IN HEALTH CARE AND SOCIAL PROTECTION

4.3.1 ENSURING ACCESS TO HEALTH CARE AND PROTECTING PATIENTS' RIGHTS

Recommendation 9: Eliminate systemic barriers to access to health care

To ensure universal access to health care, including for people who use drugs and people belonging to other vulnerable populations, governments must take measures to ensure that residence registration in a particular region of the country is never a barrier to health care (both on paper and in practice). It is essential

371 UN Commission on Human Rights, "The protection of human rights in the context of human immunodeficiency virus (HIV) and acquired immune deficiency syndrome (AIDS)," Resolution 1999/49 (1999); and "Access to medication in the context of pandemics such as HIV/AIDS, malaria and tuberculosis," Resolution 2003/29 (2003), and similar resolutions, all available via www.ohchr.org.

372 *International Guidelines on HIV/AIDS and Human Rights*, 2006 Consolidated version, para 24.

373 Ibid., para 31.

374 See, e.g., World Health Organization. *Priority interventions: HIV/AIDS prevention, treatment and care in the health sector.* Geneva, 2008.

to establish free access to health care for persons without identification documents, people without a permanent residence certificate, migrants and refugees. People who use drugs, sex workers, former prisoners and migrants have a higher risk of HIV and other blood-borne infections, and are more likely not to have identification documents or permanent residence registration. Thus, providing them with information on HIV prevention and treatment and drug dependence treatment options is an important element of every country's national public health policy. Information on disease prevention and treatment options should be freely provided by the state to all people permanently or temporarily residing in its territory. If a state is not in a position to provide free treatment of HIV infection and drug dependence to foreign nationals, such treatment should be arranged on the basis of treaties between the countries in the region.

Recommendation 10: Remove HIV infection from the list of "dangerous" diseases

The inclusion of HIV infection in national lists of "diseases posing a threat to others" likely contributes to the further stigmatisation and discrimination of PLHIV by reinforcing exaggerated fears of people with these conditions — especially when it is inappropriately listed alongside other highly contagious and casually communicable diseases (e.g., airborne tuberculosis or water-borne cholera), thereby suggesting incorrectly that it carries a similar risk of transmission. Stigma and the fear of discrimination create a disincentive to people seeking testing and treatment, which is counterproductive to public health. Ensuring access to appropriate care and treatment, free of charge, for people with HIV is important, for both human rights and public health reasons. But those four countries that have a list of "dangerous" diseases (i.e., Azerbaijan, Kazakhstan, Turkmenistan and Uzbekistan) should reconsider whether it is justified to include HIV infection under this heading alongside other diseases listed, and whether there is an alternative way to ensure access to free treatment without such a stigmatizing categorization.

4.3.2 REFORMING NATIONAL PROGRAMMES AND LAWS ON HIV AND DRUGS

Recommendation 11: Ensure adequate financing for national HIV programme

In those countries where the national HIV programmes does not currently have a clear budget attached to the activities that are contemplated, or where the programme does not have a clear allocation of funds dedicated to support its implementation, the national government should immediately take the necessary steps to rectify this deficiency, including with legislative action if necessary to effect such budget allocations.

Recommendation 12: Ensure meaningful involvement of affected groups and of civil society in the development and implementation of national programmes on HIV and on drugs

In order to ensure the participation of civil society and groups at higher risk of HIV infection and drug dependence in the development of the national programmes on HIV and on drugs, and their implementation and evaluation, governments in the project countries should examine the current process(es) of involvement; and consult with groups of people living with HIV, members of vulnerable groups (including people who use drugs and people in prison) and NGOs providing HIV- and drug-related services to identify ways in which their input and participation can be more systematically encouraged and sustained.

Recommendation 13: Ensure explicit commitment to human rights, particularly of higher risk groups, as key principle of national HIV response

The national HIV programmes of the project countries rarely address the issue of respecting, protecting and fulfiling the human rights of vulnerable groups. Several steps are recommended:

1.1 It is recommended that the lead government agency responsible for the development and implementation of the national HIV programme (usually the Ministry of Health) revise the programme so that it states clearly a commitment to respecting, protecting and fulfiling human rights as part of not only complying with international legal obligations but also as a necessity of making the national HIV programme results-oriented and effective in achieving the targets set. This commitment should include an explicit recognition of the need to respect, protect and fulfil the human rights of those groups most vulnerable to HIV (including people who use drugs and people in prison) and prescribe concrete interventions for achieving these goals.

1.2 In line with this commitment to human rights as a central part of an effective response to HIV, where it is not already the case, the national HIV programme should include, as distinct element, measures aimed at educating the public at large and certain targeted populations (e.g., health care professionals, law enforcement personnel, prison authorities and personnel) about HIV and about challenging the stigmatization and discrimination experienced by people living with HIV, people who use drugs and people who are or have been in prison.

Recommendation 14: Ensure that national programmes on HIV provide for systematic education and training of workers in key sectors such as health and law enforcement

1.1 The national programme on HIV, and the relevant departmental regulations that should be guided by it, need to provide for continuous and regular training on the latest methods of HIV prevention and treatment, as well as on human rights, for health care practitioners (including psychologists, psychiatrists and those specializing in narcology) and social workers. Curricula for health practitioners should include training on counselling regarding HIV infection and testing.[375]

1.2 The national programme should similarly provide for such training for law enforcement personnel.

Recommendation 15: Introduce an explicit commitment to addressing HIV infection among people who use drugs in relevant national programmes on HIV and drugs

In order to help achieve the goal of "universal access" to HIV prevention, care, treatment and support, and to ensure their national responses to HIV are effective in addressing HIV among a particularly vulnerable population, project countries should take a number of steps in relation to both their national programmes on HIV and their national programmes on drugs, as follows:

1.1 Where it is not already the case, project countries should introduce a clear and explicit commitment to addressing HIV among people who use drugs as part of their *national HIV programme*. This should include explicit reference to harm reduction measures as a fundamental component of the national HIV programme, relevant to both HIV prevention among people who use drugs and HIV treatment, care and support for people who use drugs and are tested HIV-positive.

1.2 Similarly, where it is not already the case, each of the project countries should revise its *national programme on illicit drugs* by incorporating clear, explicit reference to harm reduction as a fundamental component of the national strategy. Preventing HIV infection and other harms among people who use drugs, and ensuring access to necessary care, treatment and support for those who are tested HIV-positive, should be explicitly identified among the objectives of national policy on drugs (and reference should be made to the national HIV programme that outlines in more detail the measures to be taken).

1.3 In all of the project countries, reference to harm reduction measures as part of the national HIV programme should be strengthened with more explicit and detailed *enumeration of the kinds of measures that are to be implemented for addressing HIV among people who use drugs*, including adequate access to needle and syringe programmes and opioid substitution therapy. (It should be made clear in the programme that this is not an exhaustive, closed list of measures, but rather an open-ended list that identifies some of the most critical initiatives as examples.)

375 WHO Regional Office for Europe, "HIV/AIDS Treatment and Care: WHO Protocols for CIS Countries" (Copenhagen, 2004).

Recommendation 16: Introduce an explicit commitment to addressing HIV prevention, care, treatment and support in the prison system in relevant national programmes on HIV and in national or sectoral programmes of the correctional system

In order to help achieve the goal of "universal access" to HIV prevention, care, treatment and support, and to ensure their national responses to HIV are effective in addressing HIV among a particularly vulnerable population, project countries should take a number of steps in relation to both their national programmes on HIV and any national programme or plan governing the correctional system, as follows:

1.1 Where it is not already the case, project countries should add a clear and explicit commitment to addressing HIV prevention, care, treatment and support in the prison system as part of their *national HIV programme*.[376] This should include explicit reference to the reality that activities that may transmit HIV, including sexual activity and drug use, occur in prisons and that these need to be addressed with initiatives that are based on evidence and that respect the human rights of people in prison.

1.2 Similarly, where there is a *national programme on the reform of the correctional system*, this should be revised to incorporate clear, explicit reference to the objectives of respecting and protecting the human rights of people in prison, as well as preventing HIV infection among people in prison and ensuring access to necessary care, treatment and support for those people in prison who are tested HIV-positive. (The national programme on the correctional system should make reference to the national HIV programme that outlines in more detail the measures to be taken.)

1.3 In all countries, the *national HIV programme should make explicit reference to the kinds of measures that are to be implemented in prisons* for HIV prevention, treatment, care and support. This should include, at a minimum, the kinds of measures recommended in Section 5 below, including easy, discrete access to the following: information about sexual transmission of HIV and transmission through sharing of injection or tattooing equipment; voluntary testing and counselling for HIV and STIs; condoms; bleach and other disinfectants; sterile injecting and tattooing equipment; opioid substitution therapy and other voluntary methods of treatment for drug dependence; and treatment for tuberculosis and STIs, as well as, for those who are tested HIV-positive, ART and other necessary medications and aspects of HIV-related health care. It should also note explicitly that NGOs can play an important role in HIV prevention, care, treatment and support in prisons. (It should be made clear in the programme that this is not an exhaustive, closed list of measures, but rather an open-ended list that identifies some of the most critical initiatives as examples.)

1.4 The national HIV programme and any national or sectoral programme on the management of the correctional system should each contain an *explicit commitment to the principle of equivalence* — namely, that people in prison will have access to health care information, goods and services, including for HIV prevention, care, treatment and support, that is equivalent to the access enjoyed by those outside prisons.

Recommendation 17: Update or adopt new legislation on HIV where necessary and appropriate

In all of the project countries, the national expert groups have recommended the amendment of existing laws on HIV or the development of a new law on HIV. Common issues that require attention are summarized as follows:

- The national HIV law should set out explicitly the goal of universal access to goods, services and information for HIV prevention and for HIV care, treatment and support, in the general community and also within prisons on a basis equivalent to access in the community.
- The national HIV law should include specific provisions identifying measures that should be taken for HIV prevention and treatment among particularly vulnerable groups, explicitly including people who use drugs and people in prisons among others (e.g., sex workers, MSM, youth, women at risk). The law should explicitly mandate that the national response to HIV include harm reduction measures (e.g. OST, NSPs); the law should be clearly worded such that these are not the only measures to be taken but rather are some of the most critical initiatives.
- The national HIV law should explicitly articulate the requirement to involve PLHIV, members of vulnerable groups and civil society organizations engaged in HIV-related work in the development, implementation and evaluation of policies and programmes. There should be a clear legal basis for NGOs to engage in various activities and deliver various services (including harm reduction programmes, and including within prisons) to help achieve universal access to HIV prevention, care, treatment and support.
- National laws on HIV should include clear provisions on providing access to HIV testing, accompanied by pre- and post-test counselling, that is voluntary, informed and strictly confidential (and even require that people have access to truly anonymous HIV testing in at least some settings). The law should also include a general prohibition on imposing HIV testing under coercion.
- All national HIV laws contain explicit prohibition on discriminating against people based on their HIV status, but these provisions are rarely (or never) enforced. It is recommended that prohibition of discrimination based on actual or perceived HIV-positive status is reinforced by actual implementation guidelines and stricter interpretation of the law.
- The national HIV law should include explicit reference to the implementation of various "information, education and communication" (IEC) initiatives, including campaigns to educate people about HIV infection and its prevention (e.g., safer sex education), and about their rights and the rights of others, as well as education aimed at reducing HIV-related stigma and discrimination.
- There is a need for monitoring of effectiveness of programmes and strategies and implementation of their provisions. To this end, it is recommended that legislation (whether it be the national HIV law or a national public health law) mandate the appropriate government bodies to develop and implement methods of statistical reporting and mechanisms of quantitative and qualitative evaluation of health services and other HIV programmes.

Recommendation 18: Separate issues of drug dependence prevention and treatment from anti-trafficking measures in national programmes on drugs

National programmes on drugs should treat drug use and dependence as primarily a health concern, rather than a matter of criminal justice. To this end, project countries should either separate drug dependence treatment and drug enforcement elements of the national programme or adopt a separate programme on drug dependence prevention and treatment. In either case, health authorities, not the drug control agency, should be solely in charge of developing policies and implementing strategies regarding drug dependence prevention and treatment.

4.3.3 ENHANCING DRUG DEPENDENCE PREVENTION AND TREATMENT

Recommendation 19: Increase scope of options for voluntary treatment of drug dependence, including through new or amended legislation

Currently, in most countries, detoxification is the primary treatment approach for drug dependence, and a wider variety of treatment methods and options suggested by international organizations is nonexistent or extremely limited. All the project countries should urgently expand access to a wider range of evidence-based options for voluntary drug dependence treatment.

- In countries where there are already separate statutes addressing drug dependence treatment, there is room for strengthening those laws by mandating access to a broader range of needed services, including in particular the implementation and evaluation of OST and access to rehabilitation and psychosocial services as key elements of a comprehensive approach. For example, the

376 Some countries already have a specific strategy developed to address HIV in prisons: e.g., Government of Kazakhstan, Program for Countermeasures to AIDS and HIV Epidemics in the Penal System for 2007-2010 [Программа по противодействию эпидемии ВИЧ и СПИД в учреждениях УИС в Республике Казахстан на 2007-2010], Order of the Ministry of Justice of the Republic of Kazakhstan, No. 229 (14 August 2007).

expert team in Azerbaijan emphasizes the need to diversify treatment options, to ensure that all options are supported in the law or regulations, and to open the door for NGOs to assist in provision of evidence-based drug dependence treatment. The experts from Turkmenistan recommend providing a legislative basis for an accessible "network of [providers of] voluntary, anonymous and free treatment" with rigorous protections of confidentiality.

- Where there are no special legal acts on drug dependence treatment (e.g., Kyrgyzstan, Uzbekistan), a specialized law on prevention and treatment of drug dependence should be enacted, as suggested by the Kyrgyz expert groups.

Recommendation 20: Eliminate barriers to access to effective, affordable and confidential treatment for drug dependence

Governments in the region must urgently take measures to ensure that the cost of services to patients, and residence registration in a particular region of the country, are never barriers to care (both on paper and in practice). In many project countries, anonymous treatment is provided only on a fee-for service basis. Receiving publicly-funded treatment, where available, means providing personal identifying details, which may be passed on to others including law enforcement authorities. It also means registration as a drug user (or drug dependent person), which exposes the person to infringements of other rights (e.g., discrimination in employment or access to educational facilities). In order to enhance the existing protection of confidentiality for drug dependence treatment and thus widen access to treatment, particularly for people without the resources to pay for private treatment, it is recommended to implement anonymous or strictly confidential treatment for drug dependence at state health facilities.

Recommendation 21: Ensure access to opioid substitution treatment

All of the project countries should make it an urgent priority to offer opioid substitution therapy to all who need it at the earliest possible date. As some country experts emphasized, failing to provide OST is shortsighted in view of the gravity of the HIV infection, hepatitis C and heroin dependency challenges in the region.

1.1 **Ensure legislative basis for OST:** In all the project countries, including those where OST exists but is not institutionalized in legislation, it is recommended that the government introduce provisions for it in legislation. As suggested above, where there already exists a law on drug dependence treatment, this would be an obvious statute to amend to make explicit the legal mandate for providing OST; alternatively provisions could be added to the existing law on drugs.[377] Where there is no existing law on treating drug dependence, a new law could be enacted, and should include provisions on OST. (Given that OST is also an HIV prevention measure, reference to it could also be added to national laws on HIV.) Creating a legislative framework should not, however, delay the implementation and expansion of OST programmes, which are urgently needed in all the project countries.

1.2 **Ensure medical use of methadone is legally permitted and recognize OST medications as essential medicines:** In all six countries, buprenorphine is included on a schedule under the national law on narcotics that permits its medical use subject to strict control measures. In five of the countries, methadone is similarly scheduled; the exception is Uzbekistan, although methadone was imported twice pursuant to a special decree for purposes of OST pilot programmes (subsequently discontinued in 2009). Uzbekistan should reschedule methadone to permit its legal medical use. In all countries, including those where methadone and/or buprenorphine are already used for treatment, they should be added to the national list of essential medicines.

1.3 **Implement OST where absent and scale up in all countries:** In countries where OST does not exist (i.e., Tajikistan, Turkmenistan), OST programmes should be started. In all project countries, the government should commit to a clear timeline for evaluating their OST programmes and scaling up quickly to meet the need.

1.4 **Restart OST programmes in Uzbekistan:** In 2009, the government of Uzbekistan decided to discontinue its pilot OST programme. It is recommended that the Ministry of Health re-evaluate its decision and explore the possibilities of reinstating the programme with improved quality and safety monitoring and control.

1.5 **Develop protocols governing OST programmes to protect patients:** In order to ensure respect for human rights and overall OST effectiveness, it is recommended to develop and adopt standard procedures with regard to patient rights. For example, reducing patients' methadone doses should never be used as a means of punishing patients who do not comply with programme rules (viz. Azerbaijan). Similarly, excluding people from OST because of use of other drugs is not warranted; such a provision for mandatory exclusion should be removed from clinical protocols.

Recommendation 22: Improve training of health care professionals

Health authorities in all the project countries should invest more in training health professionals on best practices in the field of drug dependence treatment, in accordance with international guidelines.

Recommendation 23: Limit or repeal compulsory drug dependence treatment

All of the project countries should reform the current widespread application of compulsory drug dependence treatment in their jurisdictions, as was recommended by a number of the national expert groups.[378] It is recommended generally that compulsory treatment be abolished — including in the penitentiary system, where current common practices of compulsory treatment should be replaced with access to evidence-based, voluntary treatment.[379] The exception would be the rare circumstances where a person poses a serious likelihood of immediate or imminent harm to himself/herself or to others, as suggested by the UN General Assembly resolution on mental health services.[380] In all cases in which any element of compulsion is attached to treatment for drug dependence, patients should have the right to appeal the application of forced treatment to an independent tribunal.

Recommendation 24: Reform registration and reporting of people who use drugs

The national expert groups recognized the drug user registration system as a major barrier to utilization of treatment services by people who use drugs. Violations of confidentiality of patients registered with state facilities providing treatment for drug dependence particularly limits access to treatment for poor people (which will disproportionately include those with the greatest degree of drug dependence), who cannot afford to pay privately for anonymous treatment that will protect their privacy and insulate them from the negative consequences of being registered as someone who uses drugs. As noted by the experts from Tajikistan and Uzbekistan, a first priority is to abolish the free flow of information from the health system to the police and the linking of registration to denial of certain rights and services and to harsher penal sentences. Some of the experts envision reform of the system with greatly strengthened provisions for confidentiality. The caution should be raised that in any environment in which people with drug dependence are criminalised, law enforcement authorities will exert pressure on health systems to have access to information on people who use drugs.

377 For example, in Kazakhstan, where the decision to introduce OST has been made but the implementation has been delayed, these provisions could be added to the existing *Law "On medical and social rehabilitation of people with drug dependence"*, Law No. 325-II (27 May 2002) or the Law "*On Narcotic Drugs, Psychotropic Substances, Precursors and Their Illicit Traffic and Abuse Countermeasures*", No. 279-I (10 July 1998).

378 The Tajik experts called for abolition of the current law on compulsory treatment in favour of more human rights-based provisions that would limit the use of compulsory treatment to rare situations. The Uzbek team recognized the need to limit the legislative latitude to impose treatment – and specifically observed that one source that could be used to guide such reform is Legislating for Health and Human Rights: Model Law on Drug Use and HIV/AIDS – Module 2: Treatment for Drug Dependence (2006), online via www.aidslaw.ca/modellaw. In Turkmenistan, according to the national expert group, the regulations need to be clearer about when compulsory treatment can be imposed, as current practices may be inefficient and cost-ineffective.

379 E.g., WHO, UNODC & UNAIDS, Interventions to Address HIV in Prisons: Drug Dependence Treatments, Evidence for Action Technical Papers (2007), online via http://www.who.int/hiv/topics/idu/prisons/en/index.html.

380 If compulsory or quasi-compulsory treatment is to be linked to the criminal justice system as an alternative to prosecution and/or punishment, countries should consider carefully how to minimize the infringement of human rights of those being diverted from the normal criminal procedure. For more dicussion, see: Legislating for Health and Human Rights: Model Law on Drug Use and HIV/AIDS, Module 1: Criminal law issues (2006), pp. 23 (including annex on drug treatment courts), online via www.aidslaw.ca/modellaw.

The following measures are therefore recommended:

1.1 Evaluate drug user registration: In all of the project countries, it is recommended to begin an independent evaluation of the efficiency and cost-effectiveness of drug user registration with the goal to reform or abolish the system should evaluation demonstrate its lack of efficacy or perhaps even effects that are counterproductive to public health and human rights.

1.2 Reform (or abolish) drug user registries: As a priority for the reform, it is recommended in all countries to repeal (or at least significantly narrow) the provisions on registration that exist in laws and other regulations on drugs and on narcological services.

1.3 Protect confidentiality of patients on registries: Should registration remain in some form, countries must at least ensure much better protection for confidentiality of patients' identity and health information. This should include legislative amendments that:

- repeal any positive legal obligation on the part of narcological facilities and other health care facilities and personnel to disclose information about people seeking treatment, or cases of overdose, to law enforcement authorities;
- repeal the right of law enforcement authorities and prosecutors to receive such information upon demand;
- prohibit narcological facilities and other health care personnel from disclosing patients' personally-identifying information except in rare and narrowly-defined circumstances.

Recommendation 25: Prevent fatal overdoses

All project countries that have not done so should, at the earliest possible date, register naloxone as a legal medication for use in managing opioid overdoses and should add naloxone to the national list of essential medicines. They should also develop overdose prevention projects, train outreach workers and peers in life-saving procedures in case of an overdose, and explore supplying naloxone to NGO outreach workers and peers, as recommended by the national experts from Uzbekistan.

4.3.4 ENHANCING HIV PREVENTION AND TREATMENT

Recommendation 26: Ensure access to free anonymous HIV and STI testing

According to the national expert groups, national HIV laws should be reformed to include provisions for voluntary anonymous or confidential HIV testing that is available free of charge to all. Additional efforts should be made in particular to ensure that vulnerable groups (e.g., people who use drugs), have access to such free, anonymous testing and counselling. Epidemiological data that is useful in targeting HIV prevention programmes and health services to reach at-risk populations may be collected without requiring complete personal identification information. A similar approach should be adopted for testing for other STIs.

Recommendation 27: Ensure the voluntary nature of HIV testing with informed consent

Where there is any uncertainty, national legislation (and any relevant regulations, orders, decrees, or instructions) should be amended to state clearly that HIV testing is undertaken only with the specific, voluntary, informed consent of the person being tested. For greater clarity, legislation or other instruments should define that pre- and post-test counselling, and written consent, are required as part of HIV testing. The law should also make clear what mechanisms are accessible for legal redress if a person has been tested for HIV without such consent. Such legislative provisions should be accompanied by training for all health professionals on HIV and on the ethical and human rights issues related to HIV testing, as well as providing non-judgemental, good-quality counselling about HIV as part of the testing process.

Recommendation 28: Enhance protection of patient confidentiality in HIV testing

Given widespread stigma related to HIV, adequately protecting the confidentiality of HIV test results is an important factor in encouraging people to seek HIV testing. Where national law does not already provide for it, it should be amended to state clearly the obligation of all those involved in providing HIV testing services to keep test results confidential, and should provide means of legal redress for persons whose right to confidentiality of medical information is violated. In addition, HIV information, education and communications (IEC) initiatives and materials should make sure the general public has information not only on how to get tested for HIV, but also information on the confidentiality of test results.

Recommendation 29: Abolish mandatory or compulsory HIV testing in most circumstances

As noted above, involuntary HIV testing is not warranted or justified except in cases of donating blood, organs, tissues or other bodily substances. National laws should be reformed, where and as necessary, so as to abolish HIV testing that is mandatory or compulsory in all other circumstances (e.g. of people who use or are perceived to use drugs, of people suspected of being HIV-positive or perceived as being at high risk of HIV infection, of prisoners, of foreigners, as a precondition of marriage or employment, etc.) Ministries of Health should also ensure that any directive to health care professionals about these providers initiating HIV testing with patients is explicit and clear about the ethical and human rights requirement to ensure that patients offered HIV testing are given the information needed to ensure they can make an informed decision about testing, and to ensure that consent is given voluntarily.

Recommendation 30: Adopt legislation or other instruments providing clear framework for effective operation of harm reduction programmes such as NSPs

The national expert groups have put forward numerous recommendations for strengthening the effective operation of harm reduction programmes, and in particular NSPs, as a critical part of HIV prevention among people who use drugs. The following steps should be taken:

- **Amend legislative framework:** Some of the national expert groups (e.g. Azerbaijan, Tajikistan) concluded that it is necessary to establish legal regulations to govern NSPs, to provide clear legislative authority for such activities, ensure the safety of NSP staff and govern disposal of used syringes. In the case of Turkmenistan, it is recommended to implement government-funded NSPs, which do not currently exist. These programmes should involve NGOs; another, complementary option is the distribution of free syringes through pharmacies. The key objective is to ensure that people who inject drugs have easy, affordable, practical access to sterile injection equipment.

- **Pre-empt criminal or administrative liability for workers and users of NSPs:** As noted above in Section 3 (on criminal law issues), to facilitate the effective implementation of NSPs, steps should be taken to reform criminal and/or administrative laws to avoid any potential legal liability for NSP workers (including outreach workers) and users for "facilitating" or "inciting" drug use by conducting these harm reduction services. Similarly, there should be no liability for possession of trace amounts of narcotics in used injection equipment. In addition to such amendments to criminal and/or administrative laws, countries could consider adopting or amending regulatory or legal acts formalizing the status of outreach workers that would provide such legal protection (e.g. incorporating the work of outreach workers at NSPs and other harm reduction programmes into existing laws governing social workers or other kinds of health workers).

- **Ensure client confidentiality:** Maintaining the confidentiality of health care information enables NSP clients to use the services without fear that their health information may be released to law enforcement bodies or others. There should be a clear legislative prohibition on disclosing personal information of those who use NSPs.
- **Provide for non-interference by law enforcement:** It is recommended that law enforcement agencies be provided with clear directives (e.g. in legislation) regarding their non-interference in the

activities of NSPs (including the work of outreach workers). Alternatively, or in addition, agreements can be worked out between law enforcement agencies and the health authorities or NGOs operating NSPs to ensure that law enforcement practices don't interfere with NSPs' effective operation.

- **Provide for pharmacy-based distribution:** In addition to NSPs (e.g. through "trust points") sterile injection equipment should be easily available at pharmacies without limits. Countries that have restrictions of sale of sterile injection equipment at night or to persons under a certain age, or restrictions on the number of syringes that may be sold, should repeal these restrictions in the interests of public health.

Recommendation 31: Repeal compulsory treatment for HIV infection and STIs

According to the national expert groups, each of the project countries imposes administrative and/or criminal liability for refusing or avoiding treatment for HIV infection or STIs, and for refusing to disclose information about the source of one's infection and partners. As the national expert groups concluded, these sorts of provisions create additional stigma and also a disincentive for people to seek testing. They also violate privacy rights and the rights to liberty and security of the person. It is recommended that such legislative provisions be repealed.

Recommendation 32: Ensure access to free, anonymous treatment for HIV infection and STIs

In those project countries where relevant, it is recommended to:

- abolish the registration of persons with STIs; and
- formalize in legislation the provision of free anonymous treatment for HIV and STIs.

Recommendation 33: Take measures to improve access to HIV infection care, including ART and including for people who use drugs who are tested HIV-positive

To improve quality of treatment and care for people living with HIV, including those who use drugs, the following actions are recommended:

- Consider amending the national HIV law or related regulations or orders to clarify how AIDS centres and facilities providing treatment for viral hepatitis, tuberculosis and drug dependence, should coordinate the care they provide, since they will often have patients in common. Consider as well providing standards for referring people with HIV and people with drug dependence from such specialized facilities to other health facilities.[381] Turkmenistan might do well to allow independent and experienced HIV surveillance experts to assist its health system; it seems unlikely in view of the high reported number of people who inject drugs in the country that only two people could have contracted HIV.

- To improve the availability of treatment of HIV infection at facilities that are welcoming to people who use illicit drugs, it is suggested to integrate narcological, HIV and tuberculosis services to the greatest degree possible, training narcologists and TB and HIV service providers on the importance and feasibility of ART for drug users, and involving drug users in the design of programmes that are meant for them.

- As recommended above, OST services should be established at a scale commensurate with the need to give people with opioid dependence the best opportunity to succeed at ART, and integration of OST and ART provision should be achieved to the greatest degree possible.

- Establish non-punitive ways to monitor and evaluate the utilization of ART services by people who use drugs, including through non-nominal surveillance that does not violate drug users' rights to confidentiality of their medical information.

381 For example, this reflects a recommendation formulated by the expert team from Kazakhstan, which suggested to amend the national Law "*On Prevention and Treatment of HIV Infection*".

5. PRISONS

5.1 PRISON SYSTEMS AND POPULATIONS: AN OVERVIEW[382]

There were an estimated 135,000 people in prison in the project countries in 2008. As shown in the table below, the incarceration rate (number of prisoners per 100,000 people) was highest in Kazakhstan at 378 and lowest in Tajikistan at 109. (Turkmenistan, previously the project country with by far the highest incarceration rate, dramatically decreased its prison population from 489 prisoners per 100,000 people in 2007 to 224 per 100,000 in 2008.)[383] Of the six countries, Kyrgyzstan has the highest percentage of pre-trial detainees among all people in prison, at over 20 percent of the total prisoner population. The prison system is under the jurisdiction of the Ministry of Justice in all of the project countries except Uzbekistan and Turkmenistan, where it is under the Ministry of the Internal Affairs. Prison medical services in all countries are overseen by these same ministries.

The prison system in all project countries includes penal colonies (including settlement-colonies and "educational" colonies) and "prisons". They are generally divided into three categories of security regime: regular, strict and extremely strict (or, in other words, minimum, medium and maximum security levels). In all of the project countries, correctional institutions are run by the state; in theory Kyrgyzstan also allows private institutions (which raise additional human rights concern). In all countries, there are juvenile detention facilities separate from adult prisons.

TABLE 9: Key statistics on prison populations in project countries[384]

	Total number of people in prison (and date of estimate)	Percentage of people in prison who are women	Incarceration rate (no. of prisoners per 100,000 pop.)	Percentage of all prisoners in pre-trial detention	Estimated capacity and occupancy rate of prisons
Azerbaijan	19,559 (Dec 2006)	1.9%	229	13.3%	22,470 (79%)
Kazakhstan	56,012 (Jan 2008)	6.6%	378	14.4%	71,310 (78.5%)
Kyrgyzstan	8,427 (Mar 2008)	4.7%	156	20.8%	16,342 (51.6%)
Tajikistan	7,350 (Jan 2008)	1.6%	109	15.0%	11,950 (61.5%)
Turkmenistan	10,953 (2006)	12.3%	224	12.4%a	12,882 (85%)
Uzbekistan	34,000 (2008)	n/a	122	11.5%	56,300 (60%)

5.2 HIV INFECTION, DRUG USE AND RISK BEHAVIOURS IN PRISONS: CURRENT SITUATION

In a growing number of countries, there is evidence that a significant number of new HIV infections occur in prison.[385] In many countries, the prevalence and transmission of HIV in prisons are linked to the incarceration of people who use drugs and to unsafe drug use in prisons. Research and experience show that no country has succeeded in completely eradicating illegal drug use in prisons.[386] Many people in prison

382 For the purposes of this report, the term "prisons" is used broadly to denote all institutions of the correctional system, including places of pre-trial and post-conviction detention, and the terms "prisoner" or "people in prison" are similarly used broadly to include all people detained in such institutions during criminal investigations, prior to trial, after conviction and before sentencing, or after sentencing. In some instances, the label "prison" is used, reflecting the usage in some project countries, to refer to a specific kind of institution within the broader correctional system, as distinct from other places of detention such as "penal colonies." It should be clear from the context whether this narrower meaning, or the more general meaning encompassing all correctional institutions, is intended.

383 For purposes of comparison, the highest estimated national incarceration rates in 2008 were in the USA (756 per 100,000), Russia (629) and Rwanda (604). The lowest rates are recorded in western Europe: Iceland (44) and Norway (69). For more details, see World Prison Population List, 8th ed. (January 2009) at http://www.kcl.ac.uk/depsta/law/research/icps/publications.php.

384 The table was compiled using data provided by the national expert groups from the six project counttries and from the World Prison Population List, 8th ed. (January 2009), the World Pre-Trial/Remand Imprisonment List (January 2008), and individual country information available from the International Centre for Prison Studies at King's College London, online via http://www.kcl.ac.uk/depsta/law/research/icps/publications.php/; and the World Female Imprisonment List, also published by ICPS and available at http://www.unodc.org/pdf/india/womens_corner/women_prison_list_2006.pdf.

385 K. Dolan et al, "Review of injection drug users and HIV infection in prisons in developing and transtional countries," UN Reference Group on HIV/AIDS Prevention and Care among IDUs in Developing and Transitional Countries, 2004; S. Caplinskas & G.Likatavicius, "Recent sharp rise in registered HIV infections in Lithuania," *Eurosurveillace Weekly* (2002); 6(2).

386 Dolan et al, ibid.

have a history of drug use or use drugs during their imprisonment. In many countries, policies of actively pursuing and imprisoning those who produce, traffic, possess or consume illegal drugs have significantly increased prison populations and have led to prison overcrowding. In addition to those who enter prison with a history of drug use, some people begin using drugs while in prison as a means to cope with living in an overcrowded, hostile and often violent environment. Similarly, despite its prohibition in many jurisdictions, sexual activity also occurs within prisons and often, because of prison policy, without adequate access to condoms to reduce the risk of transmitting HIV. People living with HIV are particularly vulnerable to harm in prison environments. Many prisons have unsanitary conditions and are unequipped to provide the proper counselling, education and medical treatment required to respect the rights and preserve the health of people tested HIV-positive. Since the great majority of incarcerated people return to their communities after serving their sentences, and since many people who have been in prison move repeatedly between prisons and the general community, large segments of the population are affected by the presence and spread of HIV in prisons, as are personnel working in prisons.[387]

Drug policy and prison health policy intersect importantly in the project countries since a significant percentage of prisoners are or have been incarcerated for drug-related crimes. For example, in Tajikistan, an estimated one-third of those in prison had previously injected drugs[388] and according to the national expert group, one-third were serving sentences for drug-related offences at the time of their review in 2007. At the time of reporting, the expert group from Uzbekistan indicated that 21.4% of people in prison were serving drug-related sentences. The expert reviewers in Azerbaijan estimated that over 7000 people in the prison system were treated for drug dependence from 1989 to 2007. The expert group from Turkmenistan reported that, as of 2007, 19% of those in prison were serving sentences for drug-related offences. According to the national experts from Kyrgyzstan, as of October 2007, approximately 15% of people in the country's prisons were serving sentences for drug-related offences, and UNODC reports that several studies in Kyrgyzstan indicate that 35-60% of prisoners use drugs, half of them by injection.[389]

In most countries worldwide, the prevalence of HIV infection and hepatitis C virus (HCV) is higher among people in prison than in the general population. In prison, people may face greater risks of exposure to HIV through unprotected sex (consensual and non-consensual), and through the use of non-sterile equipment for tattooing (a common practice in many prisons according to data from many countries) and the injection of drugs. In countries where a significant percentage of the prison population injects or has injected drugs, prisoners represent a group facing an elevated risk of infectious diseases.

The national expert group reported that documented HIV prevalence among people in Azerbaijan's prisons was 2.3% in 2007, and that as of that year, 72% of all people living with HIV in Azerbaijan had been imprisoned at some time. In Tajikistan, the expert reviewers reported that in 2007, of all people living with HIV in the country, 70% were injection drug users and 21% were in prison; HIV prevalence in correctional institutions was estimated by official sources at 6.2% (some other sources put the estimate higher), while HCV prevalence was an estimated 24.3%. In Kyrgyzstan, the expert group reported 178 prisoners known to be tested HIV-positive as of 2008; data on mode of infection was not available. In Kazakhstan, in a 2006 survey of people in prisons, 44% agreed that drugs are being used in prisons, 24% reported that people share injection equipment in prison, and only 12% said that shared syringes are disinfected. In addition, 40% of prisoners surveyed agreed that prisoners have sexual relations with other prisoners, and "less than half" use condoms. Almost one in three cases of HIV infection in the country was found diagnosed in penal institutions, and in 2007, 600 HIV cases were registered in Kazakhstan's prisons, representing an increase in HIV prevalence from 1% in 2006 to 2% in 2007.[390] In striking contrast to the situation reported by other project countries (and most other countries), the national expert group of Turkmenistan claimed that there are no narcotics in that country's prisons and that no cases of HIV infection or HCV have been documented in prison.

In some of the project countries, prison policies and practices other than those related to health services may undermine the right to health of people with drug dependence or living with HIV. For example, maximum-security environments are less likely to be the most conducive to implementing or using health services.

387 WHO/UNODC/UNAIDS, *Policy Brief: Reduction of HIV transmission in prisons*, 2004.

388 UNODC, *Central Asia: Kyrgyz Republic, Tajikistan and Uzbekistan: R*egional study on drug use and HIV/AIDS, Regional Summary, 2007, p. 52.

389 UNODC, "Kyrgyzstan: General Information" (2008), on file; and *Central Asia Regional Study on Drug Use and HIV/AIDS*, p. 36

390 National AIDS Centre, *Sentinel Epidemiological Surveillance Report* (2007).

5.3 CURRENT LAW, POLICY AND PRACTICE REGARDING HIV INFECTION AND DRUG USE IN PRISONS

The table below provides a summary assessment of the situation with regard to policies and practices related to HIV infection and harm reduction in prisons in the project countries. It is based in part on the reports from the national expert groups' assessments in each of the countries.

Table 10: Policies and practices related to HIV infection and harm reduction in prisons

	Azerbaijan	Kazakhstan	Kyrgyzstan	Tajikistan	Turkmenistan	Uzbekistan
Information about HIV provided to prisoners	Yes	Yes	Yes	Yes	Yes	Yes
HIV testing of people in prison	Voluntary	Conflicting legal rules in place, though penitentiary authorities claim that HIV testing is voluntary (see country report)	Voluntary	Voluntary	Compulsory	Voluntary
ARV therapy provided to prisoners	Yes	Yes	Yes	Yes, but access is limited	No	Yes (since Jan 2008)
Condoms provided to prisoners	No	Yes	Yes	Yes, but access is limited	No (and same-sex practices forbidden by Criminal Code)	No (and same-sex practices forbidden by Criminal Code)
Nature of treatment for drug dependence within prisons	Both voluntary and compulsory (detox. only)	Both voluntary and compulsory (both abstinence-oriented), in reality very few undergo voluntary treatment	Both compulsory and voluntary (includes counselling, information, psychosocial support). Voluntary treatment: Atlantis programme and OST	Compulsory (detox. only)	Compulsory (detox. only)	Compulsory (detox. only)
Opioid substitution treatment provided in prisons	No	No	Yes (as of 2008); limited access	No	No	No
Bleach or disinfectants provided to prisoners	No	Yes	Yes	Yes, but access is limited	Yes	Yes
Needle and syringe programmes in prisons	No	No	Yes	No	No	No
Segregation of people with HIV within penitentiary	No	No	No	No	No (but officially no prisoners with HIV)	No
Compassionate release of people with AIDS	In theory, although AIDS is not named explicitly as a specific diagnosis warranting release	In theory	In theory	In theory	In theory	In theory
Eligibility for transfers, temp. absences of PLHIV and people who use drugs	No	No	No	No	No	No

HIV prevention: addressing sexual transmission and drug injection in prisons

In some countries, drug use in prison is recognized by the authorities (e.g., Kyrgyzstan, Kazakhstan, Tajikistan), but there remain very few prison-based programmes to protect people who inject drugs from infectious diseases and other harms.

Bleach is provided in most of the project countries, but it appears that prisoners are not given information about the most effective use of bleach to clean equipment used for drug-injection (or tattooing), and are not allowed to seek and use bleach confidentially. Based on the best available evidence, bleach is also not considered an acceptable substitute for access to sterile injection equipment (see more detailed discussion below).

With respect to harm reduction services Kyrgyzstan's policies are the most advanced of the six project countries. Since 2002, the Ministry of Justice has established 14 needle exchange programmes in 10 correctional facilities in the country; at this writing, none of the other project countries offered this service in prisons. In addition, Kyrgyzstan has a pilot OST programme in one colony and 2 pre-trial detention facilities.[391] Other HIV prevention efforts in the Kyrgyz prison system include: the provision of information about HIV; counselling and referral for testing for HIV, STIs and viral hepatitis; workshops, trainings and individual support; the distribution of condoms; and provision of disinfectants. Peer education about HIV and risk reduction is carried out only in prisons (and not in pre-detention facilities).

Kazakhstan's prisons provide condoms, disinfectants and information about HIV, including through peer education; NGOs provide some services in prisons. Condoms are also provided in Tajikistan's prisons, although the national expert group reports that access is unsatisfactory. According to reports from the other countries, if condoms are available at all in Azerbaijan, Turkmenistan and Uzbekistan, then it is only for conjugal visits. In the last two countries, efforts to prevent sexual transmission of HIV and other sexually transmitted diseases in prisons are hampered by the general criminal prohibition of sex between men, which makes HIV prevention in prisons harder; as recommended above, these laws should be repealed as a matter of compliance with international human rights law and in the interests of public health.

Drug dependence treatment in prisons

Although OST is not available in prisons in the project countries other than Kyrgyzstan, the national expert groups report that some form of treatment for drug dependence is available in prisons in all countries. In all countries, drug dependent prisoners are subject to compulsory drug dependence treatment. According to the legislation, voluntary drug dependence treatment in prisons is provided in all project countries. However, the national experts note that in reality very few people in prison who need drug dependence treatment undergo it voluntarily. According to the expert group in Kazakhstan, methods of drug dependence treatment in the penitentiary are very limited. People continue using drugs in prison, even if they are referred to compulsory treatment. Very few reveal their drug use/dependence and request treatment voluntarily. If drug dependence is found in a prisoner who is not referred to compulsory drug dependence treatment, s/he is offered voluntary treatment. If s/he refuses, a medical commission drafts a recommendation to a court to refer the person to compulsory treatment. Every country's *Criminal Code, Criminal Procedure Code* and sometimes *Penal Code* include articles providing for compulsory drug dependence treatment, which provisions are widely implemented. Compulsory treatment is commonly ordered by the courts as part of sentencing, in addition to other criminal penalties — even though international drug control treaties explicitly allow for *alternatives* to conviction and incarceration for drug offences, including providing treatment and rehabilitation services, instead of imposing these *in addition to* criminal penalties.[392]

People obliged to undergo drug treatment in prison are housed separately from others. For example, in Uzbekistan the duration of compulsory in-patient treatment is up to two months; followed by out-patient treatment for up to two years.[393] Treatment generally consists of detoxification, meaning the alleviation of withdrawal symptoms using tranquilizers and "nootropics" (medicines that purport to improve cognitive function).

391 S. Mamatov, Director of the National AIDS Centre of Kyrgyzstan, Press conference dedicated to the presentation of Jonathan Mann Award, available at www.24.kg/community/2007/11/29/69753.html.

392 *Single Convention on Narcotic Drugs*, 1961, UN, 520 UNTS 331, as amended by the 1972 Protocol, Article 36(2); *Convention on Psychotropic Substances*, 1971, UN, 1019 UNTS 175, Article 22; *Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances*, 1988, Article 3(4).

393 This information was provided by the UNODC Regional Office for Central Asia [on file].

Table 11: Drug dependence treatment in prisons
[Source: UNODC ROCA National Programme Officers, 2009]

Country	Number of people in treatment, and duration of treatment	Compulsory treatment		Voluntary treatment	
		Inpatient/outpatient treatment	Whether people in treatment are held separately	Inpatient/ outpatient treatment	Whether people in treatment are held separately
Azerbaijan	More than 2200 annually (2007-2008) Term is determined by judge in the range: 6 month- 2 years	Both inpatient and outpatient. In 2008, 200 narcological beds (36%) of all beds in penitentiary medical service (500)	Inpatient – yes; outpatient – no	Both inpatient and outpatient.	Inpatient – yes; outpatient – no
Kazakhstan	In 2007, in the penitentiary system, there were 5719 people registered as drug dependent, 3169 of whom were treated compulsorily. In 2009, there were 6130 people, of whom 3644 were undergoing compulsory treatment. Terms of treatment: 6 months-2 years.	Special facilities for treatment of prisoners with drug dependence were discontinued in 2007. Out-patient treatment is carried out in medical department of the penitentiary. If necessary, treatment may be provided on in-patient basis (60 beds).	Patients are not segregated.	According to the *Law "On drugs"* both in-patient and out-patient treatment exists.	Patients are not segregated.
Kyrgyzstan	In 2008, 391 prisoners were treated compulsorily. Term of compulsory treatment: up to 12 months. Voluntary treatment in the Centre Atlantis (12-Step Programme): 115 people (2007); 127 people (2008); 80 people (Jan-Jun 2009). OST 79 (Jan-Jun 2009)	Inpatient treatment is conducted in the Narcological centre of the Central Hospital ИК-47, where there are 150 beds. After inpatient treatment people are provided with outpatient aftercare.	During inpatient treatment patients are kept in the Central Hospital. During outpatient treatment they are not segregated from the general population.	Outpatient treatment is conducted within the framework of OST. There are two options for inpatient treatment: (a) in the Central Hospital; or (b) rehabilitation in the Atlantis programme (for 4-6 months).	In the Atlantis programme and in the Narcological Centre of the Central Hospital ИК-47 patients are separated from the general population. OST patients are not separated.
Tajikistan	In 2008, 206 patients were treated on a compulsory basis. Treatment consists of psychological counselling only. Term of treatment is two years and then the patients are given aftercare ("control group") up to five years	No special beds.	No	Only out-patient	No
Turkmenistan	In 2005, there were 3318 people, and in 2006, 2999 people, with drug dependence in the penitentiary who received some medical assistance Terms of treatment: 3-6 months	There are no special beds for treatment of drug dependence. When a person is admitted to prison system, s/he is segregated for 10 days in a medical unit for detoxification if needed. There is no other treatment.	Prisoners with drug dependence are held separately during detoxification	None	N/A

Uzbekistan	Approximately 10% of all prisoners have drug dependence diagnosis and receive treatment compulsorily. Terms of treatment: up to 18months	Total number of beds for all conditions are 1700, no separation based on diagnosis.	Yes	Both in-patient and out-patient	Yes

HIV-related information, counselling and testing

As noted in the table above, in most of the project countries, people generally have access to some level of information about HIV in prison. However, it is advisable to increase opportunities to have access to such information as well as counselling from knowledgeable counsellors (including from NGOs) in private settings where confidentiality is guaranteed. This is particularly crucial in closed settings such as prisons where confidentiality is often disregarded but the stigma related to HIV can provoke discrimination or even violence against people identified as HIV-positive or perceived as belonging to a "risk group" associated with HIV, who have limited ability to escape such treatment given their confinement.

According to the reports of the national expert groups, HIV testing on a voluntary basis (upon request by a prisoner) is available in prison in all the project countries. In several countries, even if the domestic "HIV/AIDS law" only provides for involuntary HIV testing for blood donors and foreigners, subsequent orders from the Ministries of Health, Justice and/or Internal Affairs have imposed compulsory testing of people upon arrival in prison and, in some cases, 6 months after admission. In Azerbaijan, legislation on compulsory HIV testing in prisons remains unclear. The situation is also unclear in Kazakhstan, given apparently contradictory provisions in the law.[394] HIV testing of prisoners in Turkmenistan is involuntary

Although counselling is an important part of the HIV testing process as a matter of both human rights and good health practice, not all the project countries make it available to people in prison. . Counselling is available in Kazakhstan, Kyrgyzstan and Tajikistan. According to the Kyrgyz national expert group, counselling that is done in prisons (though regularly performed) is not of high quality, there are no procedures for quality control of counselling.

Treatment of HIV infection, STIs and other diseases

People with HIV have access to ARVs in prison in all of the project countries but Turkmenistan, which officially has reported only 2 HIV cases in the entire country, neither of them in prisons. In 2006, in Kazakhstan 115 persons received ARV in prisons, but in 2007 only 63 persons were continuing treatment (adherence is 55 percent). The expert group in Tajikistan reports that while there is some access to ARVs in prisons, it is unsatisfactory. Uzbekistan began offering ARVT only in 2008, so it is early to judge the adequacy of access.

Treatment for tuberculosis, a significant public health problem in prisons in the region, is available in prisons in all of the project countries. Evidence-based treatment of viral hepatitis C is not available in prisons of the project countries.

Discrimination based on HIV infection and/or drug dependence in prison systems

In Azerbaijan, Kazakhstan, Kyrgyzstan, Tajikistan and Uzbekistan, people ordered to undergo compulsory treatment for drug dependence in prison are not eligible for transfer to minimum-security institutions, even if a less harsh environment would assist their treatment. In some countries, the same applies to prisoners with infectious diseases, including HIV infection (i.e. Uzbekistan).

In addition, in all project countries people who have not completed the required course of drug dependence treatment and people with HIV cannot get a temporary short leave from the penitentiary in case of emergency, and cannot be moved from one facility to another (or court) together with other prisoners and without escort. Such limitations on the right to transfer to less harsh facilities and on movement with other prisoners, on the basis of HIV status or drug dependence, is unjustified discrimination.

394 As the national expert group of Kazakhstan notes, in accordance with a joint order of the Ministry of Health and the Ministry of Justice, the Committee of the Penitentiary System under the Ministry of Justice is instructed to carry out HIV testing on a voluntary and anonymous basis with counselling on information about diseases, risk of infection, and prevention. However, in accordance with the national law on HIV and AIDS, people in prison are subject to involuntary (but confidential) testing for HIV. See the Kazakhstan country report in Part II for more detail.

Compassionate release

In all of the project countries, the law allows compassionate release from prison of people with terminal illness; this is generally thought to be available to at least some patients diagnosed with AIDS, although usually AIDS is not specifically mentioned. One of the exceptions is Uzbekistan, where according to the list of diseases for which compassionate release may be allowed, there is specific reference to AIDS. However, a more human rights-based and beneficial practice would be to ensure access to adequate treatment of HIV infection for people in prison so that the great majority of people living with HIV do not advance to the later stages of the infection (AIDS).

NGOs' role in providing services in prisons

In some of the project countries, NGOs working in health care and HIV prevention can gain access to prisons, after receiving a special permission from the correctional institution. In Azerbaijan, the law explicitly states that NGOs may carry out HIV education activities in prisons; their involvement is generally limited to providing information and trainings.[395] In Kyrgyzstan, legislation also provides for the involvement of NGOs in activities such as providing information about HIV infection and its prevention, as well as distribution of condoms and other personal items (e.g., razors).[396]

5.4 RATIONALE FOR PENAL REFORMS

Human rights standards and best practice guidelines for addressing HIV in prisons

There is an important body of human rights law and standards related to treatment of prisoners, including health services in prison, to which all the project countries are parties. Reference is made here to some of the more prominent of these treaties, declarations and guidelines.[397]

The *International Covenant on Civil and Political Rights* requires that prisoners be treated humanely and with respect for their dignity.[398] The *Convention against Torture and Other Cruel, Inhuman, or Degrading Treatment or Punishment* prohibits such abusive treatment or punishment, including in prison settings.[399] All persons, including those in prison, enjoy the right to the highest attainable standard of health, as embodied in the *International Covenant on Economic, Social and Cultural Rights*, which requires health goods, services and information to be available and accessible.[400]

A number of additional international instruments specify protections for the human rights of people in state custody. The *UN Basic Principles for the Treatment of Prisoners were* adopted as a UN General Assembly resolution in 1990; these principles underscore that the right to the highest attainable standard of health goods and services, as well as the respect, protection and fulfilment of other human rights, should not be restricted because of the fact of imprisonment. That is, as the *Basic Principles* note, incarcerated persons retain the same rights and freedoms as all other persons "except for those limitations that are demonstrably necessitated by the fact of incarceration."[401]. These principles are complemented by the *UN Standard Minimum Rules for the Treatment of Prisoners* (1955) that provide a set of guidelines designed to ensure respect for rights of people in prison, including the right to adequate health care and living conditions.[402]

A crucial point made explicit in the *Basic Principles for the Treatment of Prisoners* is that people in prison have the right to health goods and services that are the equivalent of those available to people outside

395 *Penal Code*, Article 20.

396 *Penal Code of Kyrgyzstan*, Law No. 142 (13 December 1999), Article 22, and *Law "On bodies and establishments of the penitentiary system"* [Закон об органах и учреждениях уголовно-исполнительной (пенитенциарной) системы], Law No. 197 (12 August 2003), Article 37.

397 For a more comprehensive listing and discussion of human rights treaties, international guidelines and consensus statements relevant to government action on HIV and prisons, see: WHO, UNODC and UNAIDS, "HIV/AIDS Prevention, Care, Treatment and Support in Prison Settings: A Framework for Effective National Response" (2006), pp. 5-6, online via http://www.who.int/hiv/topics/idu/prisons/en/index.html.

398 *International Covenant on Civil and Political Rights*, Article 10(1).

399 *Convention Against Torture and Other Cruel, Inhuman, or Degrading Treatment or Punishment,* 1465 UNTS 85, 10 December 1984.

400 *International Covenant on Economic, Social and Cultural Rights,* Article 12.

401 United Nations General Assembly, Basic Principles for the Treatment of Prisoners, UNGA Resolution 45/111 (14 December 1990), Article 5, available at www.unhchr.ch/html/menu3/b/h_comp35.htm.

402 UN, *Standard Minimum Rules for the Treatment of Prisoners*, adopted by the First United Nations Congress on the Prevention of Crime and the Treatment of Offenders, Geneva, 1955. Articles 22 through 26 set out basic minimum access to health care and treatment for prisoners, including the availability of medical officers and access to hospitals.

prisons in the country in which they are incarcerated.[403] That is, for example, if methadone programmes are available to people outside prison, they should be available inside prisons as well, as there is no convincing case to be made that the limitation of this service in prisons is "necessitated by the fact of incarceration." This position is widely accepted by United Nations agencies and member states.[404]

Like all other people, people in prison have the explicit right to be free from discrimination on many grounds, including race, colour, sex, language, political opinion, nationality and "other status."[405] Although the treaties prohibiting discrimination do not make explicit reference to discrimination based on health status, including HIV status, member states of the UN Commission on Human Rights (now succeeded by the Human Rights Council) have repeatedly confirmed that the term "other status" in such human rights treaties should be understood to include HIV status and other health status,[406] as have other expert bodies of the UN human rights system.[407] Therefore, discriminatory treatment of people in prison based on their HIV status or drug dependence — such as segregating them or denying them services that are available to others in the institution — is contrary to international human rights law.

> Official acknowledgement of the reality of high risk behaviours and HIV transmission in prisons is an essential first step in raising public awareness and in implementing effective responses. This acknowledgement should include public support for the need to develop and implement an evidence-based, ethical, and public health-driven response to HIV/AIDS in prisons.
>
> – WHO, UNODC & UNAIDS, *HIV/AIDS Prevention, Care, Treatment and Support in Prison Settings: A Framework for an Effective National Response* (2006)

UN agencies have recognized that people are particularly susceptible to violations of their rights while imprisoned, and that people living with HIV in prisons are especially vulnerable to human rights violations, as they may face barriers to health treatment including minimal care resources and unresponsive institutions, and may avoid seeking treatment for fear of stigmatization or discrimination. In many countries, the prevalence and transmission of HIV in prisons stem in large part from the extreme criminalisation of illicit drug use, which results in the over-representation of people who use drugs in prisons, where they continue to use drugs and may be forced to inject unsafely. In addition to those who enter prison with a history of drug use, some people initiate drug use while in prison to help cope with a hostile environment. There is evidence from numerous countries that, whether linked to sex or to drug use, significant new HIV transmission occurs in prison.[408] UN agencies have noted that ensuring the health of people in prison is a broader public health imperative since the great majority of people who go to prison return to their communities after serving their sentences.[409] Nevertheless, efforts to reduce such harms are impeded in some countries by the official policy of denying that sex and drug use occur in prisons.

In view of these concerns, UN agencies and programmes – notably WHO, UNODC and UNAIDS – have produced guidelines to assist national governments in ensuring that human rights are respected, promoted and fulfiled in responding to HIV in prisons. The summary below relies on one of the most comprehensive and recent of these guidelines produced by these three agencies, *HIV/AIDS Prevention Care, Treatment and Support in Prison Settings: A Framework for an Effective National Response*, which builds on

403 Ibid., Article 9.

404 E.g., see: WHO, *WHO Guidelines on HIV infection and AIDS in Prisons* (1993), Principle 1; Council of Europe, Committee of Ministers, *Recommendation No. R (98) 7 Concerning the ethical and organizational aspects of health care in prison*, Principle 10; *UN Basic Principles for the Treatment of Prisoners*, Principle 9; UN General Assembly, *Principles of Medical Ethics Relevant to the Role of Health Personnel, Particularly Physicians, in the Protection of Prisoners and Detainees from Cruel, Inhuman or Degrading Punishment or Treatment*, Resolution 37/194 (18 December 1982), Principle 1.

405 *UN Basic Principles for the Treatment of Prisoners*, Article 2.

406 UN Commission on Human Rights, The protection of human rights in the context of human immunodeficiency virus (HIV) and acquired immune deficiency syndrome (AIDS), Resolutions 2005/84, 2003/47, 2001/51, 1999/49, 1996/43 and 1995/44, online via http://www2.ohchr.org/english/bodies/chr/regular-sessions.htm.

407 E.g., UN Committee on Economic, Social and Cultural Rights, General Comment No. 14: The right to the highest attainable standard of health, UN Doc. E/C.12/2000/4 (2000) at para. 18, online via http://www2.ohchr.org/english/bodies/cescr/comments.htm.

408 E.g., K. Dolan et al, "Review of injection drug users and HIV infection in prisons in developing and transtional countries," UN Reference Group on HIV/AIDS Prevention and Care among IDUs in Developing and Transitional Countries (2004); S. Caplinskas & G. Likatavicius, "Recent sharp rise in registered HIV infectons in Lithuania," *Eurosurveillance Weekly* (2002); 6(2).

409 WHO, UNODC & UNAIDS, HIV/AIDS Prevention, Care, Treatment and Support in Prison Settings: A Framework for an Effective National Response (Geneva, 2006), online via http://www.who.int/hiv/topics/idu/prisons/en/index.html.

earlier UN guidelines.[410] WHO, UNODC and UNAIDS highlight the following key principles as a basis for national government action on HIV and AIDS in prisons:[411]

- That health services in the general population and in prisons should be equivalent, as noted above.
- That ensuring prisoners' right to the highest attainable standard of health goods and services is good general public health practice because of the contact between prisoners and the larger community, as noted above, and also is the best way to ensure the health and safety of those working in prisons;
- That prison policies and practices be consistent with international human rights law, and that stigmatization and discrimination must be addressed explicitly;
- That prison policy, programmes, legislation and practices be based on the best available scientific evidence of their effectiveness, unswayed by political expediency and other factors;
- That all possible measures be taken to find alternatives to incarceration, including pre-trial detention, for as many persons as possible, to reduce overcrowding, which undermines the provision of health services and safe environments in prison; and
- That adequate resources be allocated to ensure that evidence-based programmes and practices are subject to rigorous monitoring and quality control.

The same guidelines from WHO, UNODC and UNAIDS recommend **comprehensive and accessible HIV-related services** in prison, which include the following:

- Confidential access to "accurate, non-judgemental and accessible information on HIV/AIDS" in user-friendly formats for all prisoners, including information on sexual transmission, drug injection, tattooing and body piercing, mother-to-child transmission and all other relevant means of transmission and on opportunistic infections (Recommendations 53-54).
- Access to voluntary and confidential HIV testing with informed consent and well-informed counselling, and complete protection from mandatory HIV testing (Recommendations 13, 62-66). Anonymous testing should be available where it is available in the community.
- Access to anti-retroviral therapy for prisoners living with HIV at the level available in the community (Recommendation 37).
- Confidential and non-discriminatory access to condoms and to sterile injecting and tattooing equipment in accordance with what is available in the larger community (Recommendation 60).
- Recognition that consensual sex occurs in prison and should not be punished, and rigorous protection from sexual violence and coercion (Recommendations 22-23).
- Protection from mandatory and random drug testing, which can encourage prisoners to inject rather than to smoke or inhale drugs (Recommendation 14).
- Access to voluntary treatment for drug dependence (Recommendation 16), including access to opioid substitution therapy at no cost to the prisoner, according to availability in the community, with assurance of continuation of treatment after release from prison (Recommendation 77). OST should be available both to those who received it before incarceration and to those who would benefit from its initiation once they are imprisoned. Where OST is not available in the community, prison and health officials should do everything possible to advocate for its availability.
- Prevention and treatment of sexually transmitted infections, tuberculosis, hepatitis and other opportunistic infections as a central part of HIV services, including services tailored to the needs of women (Recommendations 69, 71-72).
- Access to comprehensive services for prevention of mother-to-child transmission of HIV, and to treatment for infants with HIV who may be housed with their mothers (Recommendation 73).
- Protection from involuntary segregation based on HIV status (Recommendation 15), and from denial of access to programmes or services based on HIV status (Recommendation 19).
- Protection from having access to any treatment or service provided as a reward for good conduct or denied as punishment for misconduct (Recommendation 20).

410 A full list of UN guidelines relevant to HIV and prisons is found at ibid., pp. 5-6. Since that list was compiled, these three agencies have also issued a series of "Evidence for Action Technical Papers" on "Interventions to address HIV in prisons" in 2007, available via http://www.who.int/hiv/topics/idu/prisons/en/index.html.

411 Ibid., pp. viii-x.

- Assurance of informed consent with respect to all medical procedures, and rigorous systems to ensure confidentiality of medical records and information (Recommendation 46).

Similarly, *Taking Action Against HIV: A Handbook for Parliamentarians* produced by the Inter-Parliamentary Union, UNAIDS and the UN Development Programme (UNDP) to assist lawmakers in addressing HIV, recommends that governments urgently adopt or extend programmes for preventing HIV transmission in prisons. Such programmes should include all the measures against HIV transmission that are carried out in the community outside prisons, including:

- HIV education;
- voluntary HIV testing and counselling;
- condom provision and the prevention of rape, sexual violence and coercion;
- provision of sterile injecting equipment to people who inject drugs;
- drug dependence treatment, particularly opioid substitution therapy;
- measures that reduce the demand for, and supply of drugs in prisons; and
- programmes for the detection and treatment of STIs.[412]

For the benefit of legislators and other policy-makers responsible for crafting and implementing reforms to strengthen the response to HIV in the project countries, the sub-sections below provide some additional details as part of the rationale for specific reforms that are needed to address HIV and the risks of HIV infection in their country's correctional system.

Condom distribution

Studies in many countries have shown that both consensual and non-consensual sex occur in prisons, even where it is prohibited. Yet, as noted above, access to condoms in prisons remains either non-existent or limited in the project countries, a situation that falls well short of minimum standards for good HIV prevention practices, given the substantial evidence of the effectiveness of condoms in preventing HIV transmission.[413] WHO, UNODC and UNAIDS have reviewed comprehensively the evidence regarding the provision of condoms in prisons, and have concluded as follows:

- There is evidence of sexual transmission of HIV and other STIs in prisons.
- Provision of condoms is feasible in a wide range of prison settings.
- No prison system allowing condoms has reported any security problems or other major negative consequences.
- Access to condoms does not lead to an increase in sexual activity or drug use.
- Condom access is accepted by most prisoners and prison staff once it is introduced.
- Making condoms available leads to decreased risk behaviours, indicating that access to condoms may help reduce transmission of HIV and other STIs in prisons.
- Condoms and lubricants not only need to be available in prisons, they need to be easily accessible, without having to ask prison authorities for them.[414]

The *International Guidelines on HIV/AIDS and Human Rights* also recommend the availability of condoms as an important component in the prevention of HIV and the preservation of the rights of people living with HIV.[415] Making condoms accessible to people in prisons is consistent with the principle that prisoners should have the same access to health care and treatment as people outside prisons. As the use of condoms may reveal aspects of prisoners' personal lives, respecting prisoners' right to privacy is important when safer sex materials are provided.[416] The provision of condoms and safer sex materials in prisons

412 Inter-Parliamentary Union, UNAIDS & UNDP, Taking Action against HIV: A Handbook for Parliamentarians, No. 15 (2007), p. 196, online at http://www.ipu.org/english/handbks.htm#aids07.

413 SC Weller & K. Davis-Beaty, "Condom effectiveness in reducing heterosexual HIV transmission," Cochrane Database of Systematic Reviews 2002, Issue 1., Art. No.: CD003255 (DOI: 10.1002/14651858.CD003255), online: http://mrw.interscience.wiley.com/cochrane/clsysrev/articles/CD003255/frame.html.

414 WHO, UNODC & UNAIDS, *Interventions to Address HIV in Prisons: Prevention of Sexual Transmission*, Evidence for Action Technical Papers (Geneva, 2007), pp. 12-14.

415 *International Guidelines on HIV/AIDS and Human Rights*, Guideline 4, para. 21(e).

416 *The European Convention on Human Rights and Fundamental Freedoms,* art. 8, guarantees the right have one's private life respected. The *International Covenant on Civil and Political Rights* provides that nobody shall have their private lives interfered with arbitrarily or unlawfully (art. 17).

should be done in a manner that protects the anonymity of those using them, ensuring that the right to privacy is respected.

Prison-based needle and syringe programmes (NSPs) and decontamination strategies

A range of harm reduction measures such as opioid substitution treatment and the distribution of disinfectants and condoms, is common in many prison systems, including most prisons in Europe.[417] However, many prison systems are lagging behind in addressing the HIV risks associated with injection drug use in prison. Despite prohibitions on drugs in prisons, it is clear that there is widespread drug use, including by injection, in prisons in many countries.[418] Data reported by the national expert groups from the project countries is consistent with this. However, the scarcity of syringes or other injection equipment in prisons leads people to share equipment, significantly increasing the risk of transmission of HIV and hepatitis C virus (HCV). Outbreaks of HIV infection have occurred in prisons as a result of needle-sharing.[419]

Administration of disinfectants such as chloramine (bleach) to drug injection (or tattooing) equipment can reduce spread of HIV and HCV and may therefore be used as a harm-reduction technique to reduce the risk of transmitting those viruses through sharing such equipment. Bleach distribution should be accompanied by instruction on its proper use as a disinfectant in order to maximize its protective effect. To facilitate its use, bleach must be easily and confidentially accessible to prisoners and bleach possession should not carry any penalty. Studies have found no risk to institutional safety when bleach has been made available.[420] However, while bleach should be made available in prisons, the limits on its benefits as a health protection measure must be recognized. Bleach has been shown, in controlled conditions involving multiple cleanings of injection equipment, to reduce the risk of transmission of HIV, but it is unlikely in most countries that prisoners will be able consistently to apply optimal cleaning methods, given the circumstances under which injection takes place in prisons. Furthermore bleach is not as effective at killing HCV, another major risk associated with sharing injection (and tattooing) equipment. WHO, UNAIDS and UNODC advise that providing access to bleach is <u>not</u> an acceptable substitute to ensuring access to sterile injection equipment.[421]

Sterile syringe programmes have been repeatedly shown to be one of the most important measures to protect against the spread of blood-borne infection such as HIV. As such, the availability of sterile injecting equipment in prisons helps protect the right of prisoners and prison staff to the highest attainable standard of health. Furthermore, in jurisdictions where needle exchange programmes are available outside of prisons, prisoners are entitled to access similar programmes by virtue of their right to have the same access to health care services as enjoyed by people outside prison.

However, many countries, including five of the six project countries, have yet to ensure that prisoners have access to sterile syringes. Combined with other interventions, NSPs have been implemented as HIV prevention measures in prisons in a number of countries, such as Switzerland, Germany, Spain, Romania, Moldova, Kyrgyzstan, Armenia and Iran with some other countries planning for their implementation.[422] Comprehensive reviews of the evidence from such programmes have shown the following:[423]

- NSPs are feasible and affordable in a wide range of prison settings.
- Prison NSPs have been effective in a number of countries in decreasing syringe sharing among

417 European Monitoring Centre for Drugs and Drug Addiction (EMCDDA), Annual Report 2004: The state of the drugs problem in the European Union and Norway, online at http://www.emcdda.europa.eu/publications/annual-report/2004b.

418 E.g., EMCDDA, *Annual Report 2004.*

419 See studies cited in WHO, UNODC & UNAIDS, Interventions to Address HIV in Prisons: Needle and Syringe Programmes and Decontamination Strategies, Evidence for Action Technical Papers (Geneva, 2007), p. 11, online via: http://www.who.int/hiv/topics/idu/prisons/en/index.html.

420 WHO, UNODC & UNAIDS, Interventions to Address HIV in Prisons: Needle and Syringe Programmes and Decontamination Strategies, Evidence for Action Technical Papers (Geneva, 2007), p. 20, online at http://www.who.int/hiv/topics/idu/prisons/en/index.html.

421 Ibid., pp. 19-20.

422 For the most current summary of countries that have implemented NSPs in prisons, see ibid., p. 25.

423 For review and discussion of the evidence regarding these conclusions, see the following: R. Lines et al., Prison Needle Exchange: Lessons from a Comprehensive Review of International Evidence and Experience, 2nd ed. (Toronto: Canadian HIV/AIDS Legal Network, 2006), online via www.aidslaw.ca/prisons [reviewing evidence from prison needle exchange programs implemented in Belarus, Germany, Kyrgyzstan, Moldova, Spain and Switzerland]; Public Health Agency of Canada, Prison needle exchange: Review of the evidence (Ottawa: PHAC, April 2006); WHO, UNODC & UNAIDS, Interventions to Address HIV in Prisons: Needle and Syringe Programmes and Decontamination Strategies (2007); R. Jürgens, A. Ball & A. Verster, "Interventions to reduce HIV transmission related to injecting drug use in prison," Lancet Infectious Diseases 2009; 9: 57-66, online via http://www.who.int/hiv/topics/idu/prisons/en/index.html.

people injecting drugs in prison, thereby reducing the risk of disease transmission among both prisoners and prison staff.
- NSPs have not been associated with increased attacks on prison staff, or with increased initiation of drug consumption or injection. Indeed, prison guards in some countries recognize that the availability of sterile syringes protects their safety too; when prisoners are not forced to conceal injection equipment and a prisoner is permitted to have a sterile syringe for personal use, guards conducting searches of prisoners or cells are less likely to be pricked with a contaminated needle.
- In addition to reducing needle-sharing and hence the resulting risk of transmission of HIV and HCV, prison-based NSPs can lead to reduced overdose risk and a decrease in abscesses, and facilitate referral to and utilization of drug dependence treatment programmes (where available).
- Reviews of the evidence regarding prison NSPs have found no negative consequences of such programmes.

For NSPs to be successful in prisons, prisoners need to have easy, confidential access to syringes, and both prisoners and staff should be involved in the design and implementation of the NSP. Successful prison-based NSPs also feature a rigorous mechanism for safe disposal of syringes and good monitoring, evaluation and quality control.

Improving access to drug dependence treatment in prisons

WHO, UNODC and UNAIDS have produced a comprehensive review of the evidence on drug dependence treatment in prisons and its impact on HIV prevention. The review concluded that, apart from OST (discussed below), there is little data on the effectiveness of other forms of drug dependence treatment as an HIV prevention strategy.[424] However, these agencies conclude that "[g]ood quality, appropriate, and accessible treatment has the potential of improving prison security, as well as the health and social functioning of prisoners, and can reduce reoffending, as long as it provides ongoing treatment and support, post-release care and meets the individual needs of prisoners, including female prisoners, younger prisoners, and prisoners from ethnic minorities."[425] Furthermore, "[a]ftercare is essential … [and] should not be limited to facilitating continuation of drug treatment outside prison, but needs to include social support services."[426]

> "Prisoners on methadone maintenance prior to imprisonment should be able to continue this treatment while in prison. In countries in which methadone maintenance is available to opioid-dependent individuals in the community, this treatment should also be available in prisons."
>
> – *WHO Guidelines on HIV/AIDS in Prisons* (1993)

Opioid substitution therapy (OST) has a long and strong track record in prison in numerous countries and should be universally available, including as an HIV prevention measure. The "Evidence for Action" paper highlights the following conclusions:

- OST using methadone has been shown to be feasible and affordable in a wide range of prison settings.
- Prison-based OST programmes are effective in reducing injection drug use and associated needle-sharing and infections.
- Prison-based OST programmes have been shown to have additional benefits for the health of prisoners participating in the programmes, for prison systems and for the community.
- Retention in OST is associated with reduced mortality, including by helping to reduce the risk of overdose death upon release.
- OST in prisons significantly facilitates entry into, and retention in, post-release treatment compared to prisoners with access to detoxification services only.
- The risk of re-incarceration may be reduced among prisoners who receive adequate OST while incarcerated.

424 WHO/UNODC/UNAIDS, Interventions to address HIV in prisons: Drug dependence treatment, Evidence for Action Technical Papers (2007), p. 22, online via http://www.who.int/hiv/topics/idu/prisons/en/index.html.

425 Ibid, p. 20.

426 Ibid.

- OST has a positive effect on institutional behaviour by reducing drug-seeking behaviour and improving prison safety.
- Prison administrations often initially raise concerns about security, violent behaviour and diversion of methadone, but these problems have not emerged in established OST programmes.
- Both prisoners and correctional staff in many countries attest to the positive impact of OST on prison life.
- Strategies are needed to ensure continuity of treatment of opioid users as they move between the community and prison systems.
- Making OST available in prisons can help prisoners living with HIV initiate and adhere to antiretroviral therapy.[427]

Increasing access to confidential HIV- and STI-related information, counselling, testing and treatment

Obviously, access to accurate information about HIV infection and its prevention, and access to good quality counselling and testing for HIV, is a critical element of HIV prevention efforts. As noted above, WHO, UNODC and UNAIDS have recommended that prison systems ensure access to HIV testing that is *voluntary* and *confidential* — and should also ensure access to HIV testing that is truly *anonymous* in those countries where such testing is available outside prisons. In addition, they recommend that informed consent and pre- and post-test counselling be mandatory requirements of any HIV testing done in prisons.[428]

They also note that studies show that many prisoners will accept an offer of voluntary testing if results are kept confidential and testing is part of a comprehensive programme for providing HIV-related care and treatment; in contrast, policies of mandatory testing are counterproductive.[429] Studies suggest that compulsory testing is less productive and less effective in educating prisoners and changing their behaviour than voluntary testing and broad education programmes. It may also lead to a false sense of security on the part of prisoners who test HIV-negative and who think that their contacts (such as sexual activity or sharing drug injection equipment) are only with other prisoners who are also HIV-negative; something that cannot be guaranteed given the "window period" between HIV infection and testing positive for that infection using current HIV-antibody tests.[430] Furthermore, compulsory HIV testing infringes the right to security of the person, the right to privacy and the right not to be subjected to torture or to cruel, inhuman or degrading treatment or punishment.[431] All of these rights are protected by international treaties ratified by the project countries, and such a violation is not justifiable in accordance with well-established principles in international law for imposing limitations on such rights.

For the reasons outlined above, access to care and treatment for people with HIV is as much a human right for those in prison as it is outside; efforts to scale up access to care and treatment must take into account those populations behind prison walls. Furthermore, according to WHO, UNODC and UNAIDS:

> Studies have documented that, when provided with care and access to medications, prisoners respond well to ART [anti-retroviral therapy]. Adherence rates in prisons can be as high or higher than among patients in the community, but the gains in health status made during the term of incarceration may be lost unless careful discharge planning and linkage to community care are undertaken. […] Making opioid substitution therapy (OST) available in prisons to people dependent on opioids is strongly recommended. In addition to its role in the treatment of opioid dependence and the prevention of HIV transmission, OST has proven effective in facilitating delivery of and adherence to ART among people dependent on opioids. Many injecting drug users with HIV will spend time in prison, and they need to be able to access both OST and ART without interrup-

427 Ibid, pp. 16-17.

428 WHO, UNODC & UNAIDS, *HIV/AIDS Prevention, Care, Treatment and Support in Prison Settings: A Framework for an Effective National Response* (2006), Recommended Actions 62-66.

429 WHO, UNODC & UNAIDS, *Interventions to Address HIV in Prisons: HIV Care, Treatment and Support*, Evidence for Action Technical Papers (Geneva, 2007), pp. 13-14.

430 For more detailed discussion, see the section on "HIV Counselling and Testing" in WHO, UNODC & UNAIDS, Effectiveness of interventions to address HIV in prisons, Evidence for Action Technical Paper (Geneva, 2007), pp. 67-71, online via http://www.who.int/hiv/topics/idu/prisons/en/index.html.

431 Article 9 of the International Covenant on Civil and Political Rights guarantees security of the person, Article 17 prohibits arbitrary or unlawful violation by the state of the right to privacy, and Article 7 prohibits cruel, degrading, or inhuman punishment. Similar provisions may be found in the European Convention on Human Rights and Fundamental Freedoms.

tion, including when transferring from the community to the prison and vice versa.[432]

It is important to note that health care interventions — including HIV testing, treatment with antiretroviral or other medications, and drug dependence treatment — should only be undertaken with the consent of the person involved. Health care interventions done without consent, or with consent obtained under pressure or duress, infringe the right to security of the person, the right to privacy and the right not to be subjected to cruel, inhuman or degrading treatment or punishment The presence of coercive testing or treatment schemes may also discourage prisoners from seeking necessary care for fear of loss of privacy or of the treatment itself. As a result, prisoners at risk for poor health may not receive the care needed to improve their conditions and maintain the safety of others. The provision of health care only with informed consent encourages those in need of testing and treatment to seek it as appropriate.

Information regarding a prisoner's health status should be made available to that prisoner and, beyond him or her, only to those for whom knowledge of the prisoner's status is absolutely necessary (such as a health practitioner, and only if that information is relevant to the particular treatment to be provided by that practitioner).[433] There will be few instances in which a person's HIV or HCV status or drug dependence are justifiably disclosed out of concern for safety of others. The right to confidentiality should be respected regardless of the fact of imprisonment.[434] Moreover, information about one's health status can result in discrimination and other human rights violations purely on the basis of health status, especially in communities where information regarding the nature of certain health conditions, such as HIV-infection, may be scarce or where HIV-related stigma is prevalent. Ensuring confidentiality may therefore protect a prisoner against discrimination and stigmatization on the basis of his or her health status. A lack of confidentiality and the possibility of discrimination may also discourage prisoners from undergoing voluntary testing or seeking the appropriate treatment for fear that information about their health status may be released. Confidentiality affords prisoners an environment in which they can undergo testing and treatment for health conditions without fear of social or institutional violations of their human rights.

Addressing discrimination based on HIV status or drug dependence in prison policies

As noted above, the prison systems of several of the project countries restrict eligibility for transfers to less harsh facilities to people with HIV and people undergoing compulsory drug dependence treatment. Such policies are problematic for both public health and human rights reasons.

Fear of loss of confidentiality, stigmatization, and discrimination, if known or perceived to be HIV-positive, may discourage prisoners from undergoing voluntary HIV testing and may reinforce misconceptions concerning the transmission and physical effects of the virus. Segregation also undermines HIV prevention messages by encouraging the false assumption that there is "no HIV in the prison" because "everyone who is HIV-positive is segregated." Furthermore, isolating, segregating or excluding people living with HIV (or hepatitis C) in prisons from programmes on the basis of their HIV or HCV status is contrary to the right to equality and non-discrimination.[435] People with HIV should have equal access to all opportunities and amenities available to the general prison population, including work and educational programmes. According to WHO guidelines, "[d]ecisions on isolation for health conditions should be taken by medical staff only, and on the same grounds as for the general public, in accordance with public health standards and regulations."[436]

According to principles well established in international human rights law, limitations or infringements on human rights under treaties ratified by the project countries may only be justified in accordance with clear standards.[437] One key principle is that of non-discrimination, including based on "health status," which includes HIV status and drug dependence. When such harsh policies are applied to persons with drug dependence, they may reflect and reinforce the erroneous idea that treatment for drug dependence has to be harsh to be effective. There is no justification, including on any health grounds, for such policies that deny eligibility for benefits (e.g., transfer) to prisoners simply on the basis of HIV status or drug dependence.

Compassionate release

The continued incarceration of prisoners who are terminally ill, and prisoners for whom ongoing incarceration will bring serious adverse physical or mental effects or will constitute an excessive hardship, offends the underlying values of human rights law. It may also violate the prohibition against cruel, inhuman or degrading treatment or punishment, as well as the right to the highest attainable standard of physical and mental health. In the case of terminally ill prisoners, compassionate release may be necessary for prison institutions to comply with these human rights obligations. In particular, prisoners living with HIV may be highly susceptible to fatal secondary infections acquired in prison environments, and may not have access to treatment for HIV or secondary infections while in prison (though the provision of such treatment should be a matter of high priority in all jurisdictions). As part of a comprehensive national framework for addressing HIV in prisons, UNODC, WHO and UNAIDS have recommended that prison systems "provide options for the early release for prisoners in advanced stages of HIV-related illness."[438]

Addressing HIV-related risks in pre-trial detention

Even though, in principle, people should not be incarcerated while awaiting trial unless all other alternatives are unacceptable, in some countries, large numbers of people experience pre-trial detention and represent a very significant proportion of all those in state custody, exposed to the conditions in prison that are conducive to the spread of infectious disease, including HIV.[439] However, consistent with the presumption of innocence, defendants should normally be granted release prior to trial.[440] This basic human rights principle takes on even greater importance in the light of the health risks associated with detention. Pre-trial prisoners and persons under detention without sentence risk infection with HIV and other blood-borne viruses through similar means to that of the rest of the prison population, including unsafe injection drug use and unsafe sex, whether consensual or non-consensual. These risks may be exacerbated by features typical of pre-trial detention facilities, such as overcrowding and a transient population.[441] Furthermore, health care and harm reduction programmes available to the general prisoner population are often not made available to persons in pre-trial detention.[442]

Persons in pre-trial detention who require medical treatment may not receive it and those in ongoing treatment programmes may be subject to interruption of treatment. For public reasons, minimizing the use of pre-trial detention is one important element of addressing HIV in correctional facilities. Furthermore, because persons in pre-trial detention, who are presumed innocent until proven guilty, are at high risk of violation of their rights to health and security of the person, legal reform in this area should provide a legally enforceable guarantee within national legislation to trial or release within a reasonable time.

5.5 RECOMMENDATIONS FOR PENAL REFORM

The information provided by the experts in the six countries shows that there are efforts directed at HIV prevention and treatment in prisons, but there is much to be done in terms of protecting, respecting and fulfiling the human rights of prisoners with respect to HIV prevention, care, treatment and support. As noted by many of the national expert groups, the majority of people in prison eventually leave prison, meaning that any diseases acquired in prison affect public health more broadly. Furthermore, the national experts generally recognized that current policies regarding drug use, including in prisons, contribute to the likelihood of riskier drug use practices thus increasing the risk of HIV transmission. Consequently, the experts concluded that in order to address HIV effectively in prisons, governments must accept the fact

432 *Interventions to Address HIV in Prisons: HIV Care, Treatment and Support*, Evidence for Action Technical Papers, p. 5.

433 Section 31 of the WHO's 1993 *Guidelines on HIV Infections and AIDS in Prisons* recommends that "[i]nformation on the health status and medical treatment of prisoners is confidential and should be recorded in files available only to health personnel." Exceptions to this rule, such as providing information on health status to prison managers or judicial authorities, should only occur if the prisoner's consent is obtained.

434 E.g., see Article 8(1) of the *European Convention for the Protection of Human Rights and Fundamental Freedoms* and Article 17(1) *of the International Covenant on Civil and Political Rights*.

435 See, for instance, the *UN Basic Principles for the Treatment of Prisoners*, s. 2.

436 WHO Guidelines on HIV Infections and AIDS in Prisons (1993), para 27.

437 UN Economic and Social Council, *Siracusa Principles on the Limitation and Derogation Provisions in the International Covenant on Civil and Political Rights*, UN Doc. E/CN.4/1985/4, Annex (1985).

438 WHO, UNODC & UNAIDS, *HIV/AIDS Prevention, Care, Treatment and Support in Prison Settings: A Framework for an Effective National Response* (2006), Recommended Action 76.

439 M. Schönteich, "The Scale and Consequences of Pre-trial Detention Around the World," Justice Initiatives: Pre-trial Detention (Open Society Institute, 2008), pp. 11-43, online: http://www.justiceinitiative.org/db/resource2?res_id=104079.

440 See Article 9(3) of the *International Covenant on Civil and Political Rights*. Pre-trial release may be made subject to conditions, including guarantees to appear at trial and, if relevant, for execution of the judgement.

441 E.g., Human Rights Watch, *Lessons Not Learned: Human Rights Abuses and HIV/AIDS in the Russian Federation* (2004).

442 Studies have indicated that the standard of medical facilities and the accessibility of treatment may be lower in pre-trial detention facilities than in long-term prisons. In particular, harm reduction programs may be less available to those in pre-trial detention. See: M. MacDonald, "A Study of the Health Care Provision, Existing Drug Services and Strategies Operating in Prisons in Ten Countries from Central and Eastern Europe" (Helsinki: HEUNI, 2005), pp. 99-138, online: http://www.heuni.fi/32030.htm.

that drug use occurs in prisons despite efforts to prevent it and must ensure both access to good-quality, evidence-based drug dependence treatment and pragmatic, evidence-based programmes to reduce the negative consequences of drug use (including HIV transmission). The recommendations below, which reflect this approach, draw in part on the extensive recommendations from the six national expert groups. (For more detailed recommendations, specific to each particular country, see the individual country reports in Part II.)

Recommendation 34: Include provisions for HIV prevention and treatment in prisons in national strategies and programmes, clearly indicating funding sources

Although currently, the national programmes on HIV in Azerbaijan, Kyrgyzstan, Kazakhstan, Tajikistan and Uzbekistan include measures on HIV prevention and/or treatment in prisons, national expert groups underlined that there are difficulties in implementing and funding these measures. It is preferable that national Ministries of Health (as opposed to Ministries of Justice or Internal Affairs) be responsible for HIV prevention and treatment in the penitentiary. In Turkmenistan, the national HIV programme should be revised to include such measures explicitly reflecting the other recommendations presented here.

Recommendation 35: Ensure prison health care services are adequate and equivalent to those outside prisons

In each of the six project countries, the national expert group noted that health care services available in prisons are not equivalent to those available to the population at large. A number of steps need to be taken to address this gap, which is a matter of both public health and human rights concern.

- **Ensure national health authorities are responsible for prison health:** As mentioned earlier, the provision of health care in prisons is generally the responsibility of the Ministry of Justice or the Ministry of the Internal Affairs, rather than the Ministry of Health. Where this is the case, it is recommended to transfer responsibility to the Ministry of Health. This reflects the fact that people in prison should be entitled to the same efforts to protect and promote health, and to the same health services, as people outside prisons, and makes it easier to ensure that such efforts and services are equivalent. It reinforces, in the minds of both health authorities and correctional authorities, that the health of people in prisons is a key aspect of the public's health.

- **Provide for coordination of treatment of HIV infection and tuberculosis in prisons:** The national expert groups point out, that it is essential to implement effective combination of ARV treatment and tuberculosis programmes in the prisons. People with HIV are at greater risk of infection with TB, globally the most common opportunistic infection among people with HIV, particularly in the conditions that often prevail in prisons (e.g. overcrowding, poor nutrition, inadequate sanitation).

- **Ensure equivalent access to health care goods and services:** According to some country reports, prisoners often have to pay for medication and hygiene products, and access to specialised health care (STI, dental care, etc.) is often or sometimes unavailable. A review of such gaps in access is warranted in each country where this is known or suspected to be a problem, and clear actions identified to ensure access equivalent to that of people outside prisons.

Recommendation 36: Provide information about HIV and AIDS and train staff and prisoners

To some degree, all of the project countries provide information about HIV and AIDS in prisons, but the content of the information and confidentiality of the process of providing the information could be improved.

- **Mandate HIV education in prisons:** The experts in Kazakhstan, Kyrgyzstan and Tajikistan recommend that there be systematic procedures (and official instructions adopted) for ensuring that all prisoners receive HIV information when they are admitted to prison and during incarceration. For example, the Kyrgyz experts recommend that provision of HIV-related information be required explicitly in the main regulation governing the correctional system.[443]
- **Ensure educational materials address real risks of HIV infection in prison:** We recommend in addition, as suggested by the expert group in Tajikistan, that resources be devoted to improving the quality of information given, especially to developing informational materials that speak to the reality of prison, including information on risks of drug injection, tattooing and piercing, as well as on impact of sexual violence and coercion.

- **Provide for training prison staff on HIV, human rights and harm reduction:** It is recommended to include a component providing for training of prison staff on HIV, tolerance and human rights in regular trainings and advanced education, as well provide basis for it in the regulations of the penitentiary system. For example, the expert groups from both Tajikistan and Turkmenistan noted the importance of training prison staff to be able to deliver information on HIV to people in prison. In addition, as the expert group from Azerbaijan pointed out, it is advisable to give direct instruction, in both the national law on HIV/AIDS and in the national programme or strategy on HIV, about non-discrimination against people who use drugs and people living with HIV, as well as the need to implement harm reduction activities within the correctional system.

- **Provide for training peer educators:** It is also recommended that people be trained as peer educators and supported in prisons in all countries to deliver education about HIV infection and its prevention. Experience from around the world has shown that some information is best received by prisoners when delivered by peers.

Recommendation 37: Reduce sexual transmission of HIV

- **Ensure easy, confidential access to condoms:** At least three project countries (Kyrgyzstan, Kazakhstan, Tajikistan) provide condoms in prisons for the general population of prisoners, as opposed to restricting them to conjugal visits only. However, even in these countries, concerns persist about whether access is satisfactory. The expert group in Tajikistan judged condom access to be inadequate in that country's prisons, and Uzbekistan provides condoms only for conjugal visits – which means that the authorities fail to recognize that consensual sex occurs in prison and that for all sexual acts condoms are the heart of HIV prevention, as in the general population. The absence of condoms, or limited access to condoms, in prisons is a significant gap and countries should move to eliminate it immediately. Turkmenistan and Uzbekistan should urgently remove any legislative barriers to condom distribution in prison and to consensual sex among prisoners (as the effective provision of condoms in prison will depend on repealing outdated laws against sodomy or homosexual activity). In cases where there are specific laws or internal institutional rules prohibiting sex between prisoners, upon pain of disciplinary penalty, these should be repealed; for example, this has been recommended by the national expert group in Kyrgyzstan. All countries should review their internal regulations or directives governing correctional systems and ensure that programmes are in place to allow discreet and confidential access to condoms for all prisoners at all times.

- **Develop and implement programmes to address sexual violence and coercion:** Non-consensual sex is an unfortunate reality in prison systems, violating the individual health and human rights of people who experience it and damaging the public health and the integrity of a correctional system more broadly. All project countries should implement programmes to protect prisoners against sexual violence and coercion, including clear protocols for preventing rape, to provide education and testing on HIV and other STIs for prisoners, and to provide both medical and psychological treatment and support to those who suffer sexual violence in prison. Ministries of health and ministries responsible for the correctional system need to be given a clear responsibility for addressing this issue. Guidelines, standards and programmes that have been developed in other jurisdictions may be a useful source of guidance in developing and implementing national measures in the project countries.[444]

443 Ministry of Justice, Internal Regulations of Penitentiary Facilities, Order No. 164 (28 October 2003).

444 See, e.g., the model legislative provisions and accompanying commentary in Legislating for Health and Human Rights: Model Law on Drug Use and HIV/AIDS, Module 5: Prisons (and in particular pp. 34-36), online via www.aidslaw.ca/modellaw; and reports and recommendations such as the

Recommendation 38: Ensure access to disinfectants such as bleach

The provision of bleach in most of the project countries is a step forward towards comprehensive HIV prevention in prisons. The expert teams in Tajikistan, Kazakhstan, Uzbekistan and Kyrgyzstan call for establishment or strengthening of programmes that enable prisoners to have access to bleach for disinfecting injection equipment. Countries should review their regulations and directives governing correctional facilities to ensure they provide people in prison with easy, confidential access to bleach. However, given the limitations of bleach as a measure to prevent HIV infection and hepatitis C, measures to ensure access to bleach should not impede or delay the implementation of effective needle and syringe programmes.

Recommendation 39: Ensure access to sterile injection equipment

Kyrgyzstan deserves credit for its willingness to break new ground in the region by launching needle exchanges in its prisons, but attention and resources are still required to bring this service to scale and ensure its quality in all prisons in the country. The absence of sterile syringe programmes in prison in all other project countries condemns prisoners who inject drugs to, at best, a partially effective intervention (i.e., bleach, where this is available). Given the relatively high percentage of prisoners in the project countries who have a history of drug injection or inject drugs while in prison, policies and practices in this area are in need of change.

To this end, health and correctional authorities, with input from appropriate experts (including from NGOs working with people who use drugs and/or in prisons), should begin planning the implementation of needle and syringe programmes in prisons as soon as possible. Study tours to the existing programme in Kyrgyzstan or the well established programmes in Moldova or other countries should be undertaken by officials in the project countries where this intervention is not yet in place. Health and correctional authorities should review existing legislation and internal regulations or directives governing the correctional system to identify provisions that could impede the implementation of such programmes and should amend them accordingly (as has been done, for example, in Kyrgyzstan in 2008).

Recommendation 40: Introduce voluntary drug dependence treatment and limit the use of compulsory drug dependence treatment

In all of the project countries, people in prison are subjected to the possibility of compulsory nature of drug dependence treatment, which inherently infringes the right of patients not to be subjected to medical treatment without their informed consent, and is not justified except in rare circumstances. It is recommended that all the project countries abolish currently used compulsory treatment, ensure informed consent for all medical procedures, and work urgently towards offering comprehensive, evidence-based voluntary treatment for drug dependence for prisoners. The national expert groups from Tajikistan, Azerbaijan and Kyrgyzstan make the important recommendation that people in prisons should have access to voluntary treatment for drug dependence. The Kyrgyz and Kazakh experts recommend organizing full-scale rehabilitation programmes for people with drug dependence in the correctional system on a voluntary basis. The expert group of Kyrgyzstan specifically recommends that the Ministry of Justice develop official instructions regarding the procedure and conditions of providing free and voluntary drug dependence assistance to persons in the correctional system; this recommendation should be taken up by other countries as well.

Delivering drug dependence treatment in prisons should include aftercare and links to community-based treatment for those who are released from prison. The practice of requiring prisoners to pay for treatment should be abolished - treatment should always be offered without cost to the person treated.

Recommendation 41: Ensure access to opioid substitution therapy (OST) in prison

In each of the project countries, it is recommended to widen the scope of drug dependence treatment by introducing OST in prisons (or, in the case of Kyrgyzstan, expanding existing programmes). The provision of detoxification only, without other care, in all countries that participated in the project is insufficient. In light of the widespread use of opioids in the region, the fact that OST is not widely available, including to people with opioid-dependence who are in prison (except on a limited basis in Kyrgyzstan), is a matter of grave public health and human rights concern. As noted above, a large body of scientific evidence demonstrates the effectiveness and feasibility of OST in prison settings. In addition to significantly scaling up access to OST for the population as a whole (as recommended above in Section 4), it is critical that countries made OST available in prisons as one aspect of greater access overall to voluntary drug dependence treatment.

[U.S.] National Prison Rape Elimination Commission Report (Washington, D.C.: NPERC, 2009), online: http://nprec.us/publication/.

Recommendation 42: Voluntary and confidential HIV testing with consent and counselling

As noted above, most of the project countries do not currently comply with "best practice" recommendations regarding HIV testing in prisons. Only some of the project countries provide HIV testing on a voluntary basis to people in prisons as a matter of policy, but even then there is concern that in practice testing may not be fully voluntary. In some of the project countries, legislation or policy has been adopted making HIV testing compulsory for prisoners. In fact, the expert group from Turkmenistan noted that the only HIV prevention intervention in the country's prisons is compulsory HIV testing. Finally, in some countries, such as Kazakhstan, the law or policy is unclear.

- **Abolish compulsory HIV testing:** Compulsory HIV testing of prisoners is contrary to human rights norms and international standards; all project countries need to take steps to clearly abolish both the practice and any legislative or other provisions that require it or may be interpreted as requiring it. Compulsory HIV testing in prisons should be eliminated in all countries. The reviewers note that compulsory testing in prisons in Kazakhstan has been abolished in one law, but another law technically would still allow it and needs to be changed.[445]

- **Ensure confidentiality of HIV testing, consider anonymous testing:** In order to respect human rights and to maximize the willingness of people to seek HIV testing, health and correctional authorities need to ensure that HIV test results of people in prison is kept confidential and not disclosed without the consent of the person tested. In fact, the expert team in Azerbaijan recommends that the prison authorities consider the possibility of anonymous testing, a recommendation that should be considered in other countries as well.

- **Ensure access to counselling with HIV testing:** Enabling the person tested to give informed consent for HIV testing or any other medical procedure can be challenging in a prison environment, where prisoners may feel that they do not have the right to resist a procedure suggested by someone in authority, but it is required as a matter of human rights and ethical medical practice. Providing access to good-quality counselling, before and after HIV testing, is an important component of ensuring informed consent to testing.

Recommendation 43: Ensure access to ARV therapy for people living with HIV in prison

According to the national expert groups, all of the project countries except Turkmenistan have taken some action to ensure that people living with HIV in prison receive antiretroviral (ARV) therapy where medically indicated. For both public health and human rights reasons, people in prison should have access to ARV treatment on a basis equivalent to people with HIV outside prisons, a point that has been noted by several of the national expert groups.

Recommendation 44: Ensure confidentiality of drug dependence and HIV prevention and treatment in prisons

The national expert groups from the project countries noted their concern that, even among the general population, confidentiality of medical information (including HIV status and drug dependence) is often

445 The expert group of Kazakhstan recommends bringing the Law "On HIV and AIDS Prevention and Treatment" in line with practice and international standards, and repeal the provision on mandatory HIV testing of prisoners. Paras. 1-2 of the Joint Order No. 96 of the Ministry of Justice and the Ministry of Health (28 March 2005 and 13 April 2005) No. 179 "On measures of improving HIV prevention in the penitentiary institutions of the Ministry of Justice of Kazakhstan".

disregarded. This situation is exacerbated in prisons, where it can be even more challenging to maintain confidentiality of prisoners' health information, particularly if they are not seen as deserving of the same respect for their human rights because they are in prison. Where they do not already have such rules in place, the health and correctional authorities of the project countries should adopt specific regulations and procedures to mandate and protect the confidentiality of prisoners' health information; these should make explicit that they protect such information as the HIV status or drug dependence of people in prison. These regulations should include provisions for legal liability of prison staff who breach confidentiality.

Recommendation 45: Enable NGO contributions to HIV prevention in prisons

In all of the project countries, NGOs participate in HIV prevention and other educational activities in prisons in one form or another — or at least have a right to do so according to legislation. However, in many countries this participation is limited and it is not easy to obtain permission to engage in HIV prevention activities in prisons. It is recommended that the responsible authorities develop clear procedures about granting NGOs permission to operate in prisons and authorizing them, among other things, to distribute information, condoms and bleach, to operate needle and syringe programmes such as those that operate outside prisons, and to provide support to prisoners with HIV or drug dependence.

Recommendation 46: Support peer interventions

Given the important role played by peer educators in delivering education and services aimed at HIV prevention, both health authorities and NGOs should be able to train prisoners who can then function as peer educators. Peer educators can help educate other people in prison about drug dependence treatment, HIV prevention and treatment, and can contribute to such activities as the distribution of information, condoms and bleach and the effective implementation of needle and syringe programmes in prisons.

Recommendation 47: Abolish discriminatory policies within prisons

All of the project countries maintain policies that restrict the movement of prisoners living with HIV and/or those undergoing drug dependence treatment in ways not imposed on other prisoners, such as denying short leave outside of prisons in emergency circumstances or denying eligibility for transfer to facilities with less strict security or less harsh conditions. The national experts from all of the project countries recognize the importance of eliminating such restrictions; all countries should ensure that prisoners living with HIV and those receiving compulsory drug dependence treatment have the same rights as other prisoners.

Recommendation 48: Ensure possibility of compassionate release

All of the project countries have policy in place that should allow for early release of prisoners suffering from HIV-related illness. In Turkmenistan, the national expert group has recommended explicitly including AIDS among those conditions for which compassionate release can be justified. Similarly, in Uzbekistan, the expert group recommends amendments to the Criminal Code to introduce the possibility of early parole based on illness such as HIV infection. In all countries, we recommend that compassionate release or similar policies not be seen in any sense as a substitute for antiretroviral therapy and other HIV-related care that should be equivalent to the best attainable therapy for persons with HIV outside prison.

6. LEGISLATIVE DISCRIMINATION AND RESTRICTION OF RIGHTS

In general, discrimination occurs when people are treated unfairly because they belong to a particular group or have a particular personal characteristic, or simply are perceived to belong to such a group or have the disfavoured characteristic. Discrimination is based on and contributes to the fear, secrecy and denial that have been associated with the HIV epidemic since its beginnings. Around the world, discrimination against people living with and vulnerable to HIV constitutes a substantial barrier to responding effectively to the epidemic. It reinforces people's fears of testing for HIV, of disclosing their status if infected and of accessing HIV prevention and treatment lest it reveal that they are HIV positive. Discrimination drives widespread and systemic human rights abuses against people living with HIV, considerably exacerbating the experience of living with the disease. Furthermore, where discrimination is prevalent against particular populations who are already marginalised and vulnerable to human rights abuses, such discrimination renders them disproportionately vulnerable to HIV infection and makes the experience of living with HIV even more difficult.

Stigmatisation of drug use and discrimination against people who use drugs violates dignity and causes suffering to individuals and their families and friends who care for them. It also undermines or impedes the implementation of proven health measures, such as access to sterile syringes, which can help protect people against infection with HIV and other blood-borne viruses, as well as treatment for drug dependence or other health needs such as HIV-related care for those who are HIV-positive. As noted by WHO and UNODC, "in many societies drug dependence is still not recognized as a health problem and many people suffering from it are stigmatized and have no access to treatment and rehabilitation."[446]

Stigmatization and discrimination can manifest in, and be caused or reinforced by, the law or the policies and practices adopted by state bodies as well as private, non-state actors. For example, the stigma faced by people who use drugs is reinforced by the criminal laws and law enforcement practices that surround drug use (discussed above in Section 3), and by the fact that in many countries there are few legal protections against discrimination and vilification against people who use drugs.[447] Beyond criminal laws, however, there are also other aspects of the law in which discrimination is embedded. This section of the report reviews the current situation with respect to how the law in the six project countries protects against, or in some cases enacts, discrimination against people living with HIV and people who use drugs.[448] It then outlines the rationale for reforming national laws and policies to eliminate such discrimination, drawing upon relevant human rights law and principles, as well as commitments made by the project countries and international guidelines and recommendations on addressing discrimination as part of strengthening the response to HIV and ensuring universal access to HIV prevention, care, treatment and support. Finally, it offers a number of general recommendations for reform. (Country-specific recommendations for legislative and policy changes are found in the individual country reports in Part II.)

6.1 CURRENT SITUATION IN THE PROJECT COUNTRIES

The information collected by the national expert groups does not attempt to quantify the prevalence or intensity of discrimination experienced *de facto* by people living with HIV and those who use drugs in the project countries. Such a review was outside the original scope of this project, although some such examples are noted elsewhere in this report and in some of the individual country reports (e.g., discrimination against people with HIV or with drug dependence in health care settings). Rather, given the focus of this project on reviewing legislation and policy to identify necessary reforms, this project collected information regarding *de jure* discrimination, i.e. formal laws and polices regarding people living with HIV and people who use drugs that are discriminatory.

446 WHO/UNODC, *Principles of Drug Dependence Treatment: Discussion Paper* (March 2008).

447 Some people who use drugs are made more vulnerable to human rights abuses by stigma on additional grounds, including race, mental illness, unemployment and health status or record of conviction. See D. Samoilov, "Double discrimination: drug users living with HIV/AIDS," HIV/AIDS Policy and Law Review 9(3) (2004): 83–85. This article describes the discrimination faced by people living with HIV/AIDS in general, and HIV-positive people who use drugs in particular.

448 Section 6 below deals more broadly with the response to HIV and drug use in prison systems in the project countries. That section includes discussion of various kinds of discrimination encountered in the prison system by people with HIV or with drug dependence on account of their health status. It also identifies various ways in which people in prison face discrimination based on their status as prisoners, such as denial of access to important HIV prevention measures or health care services available to people outside prisons.

6.1.1 DISCRIMINATION AGAINST PEOPLE LIVING WITH HIV

Legal provisions prohibiting discrimination

All six project countries have general anti-discrimination provisions in their Constitutions. In post-Soviet legal systems, there are no specific statutes to prohibit discrimination; rather, discriminatory acts towards certain groups may be prohibited in laws concerning these groups. For example, discrimination against people living with HIV may be prohibited under a clause in the national law "On HIV/AIDS" (or some similar title). In all of the project countries, infection with HIV or the presence of AIDS-defining illnesses may be considered as a disability under the disability law.[449] National laws "On Social Protection of People with Disabilities" (or some similar title) always contain a specific article prohibiting discrimination against people living with disabilities. Employment laws may also contain non-discrimination clauses, while health laws may contain non-discrimination clauses and/or the obligation on health care professionals to render medical care to everyone. In some project countries, the violation of such non-discrimination (or equality) clauses is penalized by that country's *Criminal Code*. Similarly, in some of the countries, legislation establishes the possibility of criminal liability for a discriminatory refusal to provide medical services.

Azerbaijan's Constitution guarantees the right to health and freedom from discrimination.[450] Violations of equality can attract criminal liability.[451] The HIV law formally prohibits discrimination on the basis of HIV status in the spheres of employment, education and health care.[452] Discrimination in the workplace is prohibited by the *Labour Code* and could extend to cover workplace discrimination on the basis of HIV status.[453] However, according to the national expert group, stigmatization and discrimination against people living with HIV is widespread and represents one of the main obstacles to addressing HIV effectively in Azerbaijan. The country experts considered that stigmatisation commonly takes the form of alienation and avoidance of people living with HIV, and that families, health care professionals and the government discriminate against people living with HIV.

Kazakhstan's Constitution sets out guarantees against discrimination and guarantees the right to health.[454] The national AIDS law prohibits any sort of discrimination against people living with HIV.[455] The *Criminal Code* establishes criminal liability for "direct or indirect restriction of rights and freedoms of a person" based on a number of specific listed grounds, as well as discrimination based on "any other circumstances," an open-ended phrase that could easily be understood as encompassing at least HIV status or a health condition such as drug dependence.[456]

In Kyrgyzstan, the Constitution guarantees freedom from discrimination "on the grounds of descent, sex, race, nationality, language, political and religious beliefs, or any other grounds of personal or social characteristics."[457] According to the *Criminal Code*, direct or indirect discrimination is to be punished by a fine or "corrective works." The Constitution also guarantees the right to health.[458] The HIV law forbids discrimination against PLHIV.[459]

449 For example, according to the national expert group, in Azerbaijan's *Law* "*On Prevention of Disability, Rehabilitation, and Social Protection of the Disabled*" (25 August 1992), both HIV and AIDS are included in (separate) categories of "physical disabilities". In the rest of the project countries, AIDS-defining illnesses may be considered as disability.

450 Azerbaijan's Constitution provides for a right to have one's health protected (Article 41), while Article 25 provides as follows: "The state guarantees equality of rights and liberties of everyone, irrespective of race, nationality, religion, language, sex, origin, financial position, occupation, political convictions, membership in political parties, trade unions and other public organizations. Rights and liberties of a person cannot be restricted due to race, nationality, religion, language, sex, origin, conviction, political and social belonging."

451 *Criminal Code* of Azerbaijan, Article 154.

452 *Law* "*On prevention of the spread of AIDS in the Republic of Azerbaijan*" (1996), Article 10.

453 Azerbaijan's *Labour Code*, Article 16.

454 Article 14(2) of the Constitution of Kazakhstan reads as follows: "No one shall be subject to any discrimination for reasons of origin, social status, property status, occupation, sex, race, nationality, language, attitude towards religion, convictions, place of residence or any other status." For the right to health, see Article 29.

455 See Kazakhstan's *Law* "*On HIV and AIDS prevention and treatment*" (1994), Articles 2-4 and 7.

456 This offence is penalized with a fine or arrest for up to three months or imprisonment for up to one year. The same act committed by a person using an official status or by a managers of a social organization is penalized by a fine or arrest for up to six months, or imprisonment for up to two years along with deprivation of the right to occupy specific positions or engage in certain activities during a period of up to three years: see Article 141.

457 *Constitution of the Republic of Kyrgyzstan*, Articles 13 and 134.

458 Ibid., Article 34.

459 *Law* "*On HIV/AIDS in the Kyrgyz Republic*", Law No. 149 (13 August 2005), Article 13.

The Constitution of Tajikistan provides that "[a]ll persons are equal before the law and the courts. The government guarantees the rights and freedoms of every person regardless of ethnicity, race, sex, language, faith, political beliefs, education, or social or property status."[460] It also guarantees the right to health care.[461] According to the *Criminal Code*, direct or indirect violation of the right to equality is to be punished by a fine.[462] The national law on HIV prohibits discrimination on the basis of HIV status in certain spheres, including employment, education and health care.[463]

In Turkmenistan, according to the Constitution, equality of rights and freedoms is guaranteed, as well as equality before the law regardless of ethnicity, race, sex, origin, social or property status, place of residence, language, religion, political beliefs or association.[464] A provision of the *Criminal Code* provides for criminal liability for direct or indirect infringement or restriction of the rights and freedoms of people and citizens based on sex, race, nationality, language, origin, financial or official position, residence, religion, belief or membership in public associations.[465]

In Uzbekistan, prohibitions on discrimination are found in a number of laws. The Constitution guarantees the equality of all citizens.[466] The *Criminal Code* envisages responsibility for violating the equality of citizens.[467] It also creates criminal responsibility for a health care professional if they fail to render assistance without a legitimate excuse to a sick person.[468] For its part, the national law on HIV contains provisions preventing discrimination in employment (except in the case of certain occupations or professional activities), education and health care.[469] The legislation on health prohibits discrimination in the provision of health care and establishes that health care and pharmacy workers must render emergency medical care to everyone.[470]

Notwithstanding these varied prohibitions, including in national Constitutions, all of the project countries still have legislation in place that discriminates against people living with HIV in a variety of ways, denying them equal enjoyment of a number of human rights, as outlined in the sub-sections that follow.

Right to work

Despite the explicit prohibition on denying employment on the basis of HIV status (which may be frequently found in the national HIV laws of the project countries), a number of the countries formally prohibit people who are living with HIV from working in certain occupations or positions. Such prohibitions are often accompanied by — and made operational through — mandatory HIV testing for people working in, or applying to work in, certain positions. (For more specific details than what is summarized here, see the individual country reports in Part II.)

According to the information provided by the country experts, in Azerbaijan, there are mandatory annual medical examinations (including an HIV test) for certain occupations, including people who work in child care and people who work in the food sector.[471] People living with HIV are prohibited from working in these professions. According to the report from Kazakhstan, soldiers and conscripts must undergo HIV testing on recruitment and six months afterward.[472] People living with HIV are not hired or are discharged if already employed by the armed forces.

In Kyrgyzstan, HIV testing is carried out during recruitment for certain listed occupations and positions specified by the government; this list also includes health personnel.[473] People living with HIV are not

460 *Constitution of the Republic of Tajikistan* (1994), Article 17.

461 Ibid., Article 38.

462 *Criminal Code*, Article 143.

463 *Law* "*On counteracting HIV*" Article 13.

464 *Constitution of Turkmenistan*, Article 19.

465 *Criminal Code*, Article 145.

466 *Constitution of the Republic of Uzbekistan*, Article 18.

467 *Criminal Code*, Article 141.

468 Ibid., Article 116.

469 *Law "On prevention of illnesses caused by human immunodeficiency virus (HIV),"* Article 10.

470 *Law "On the protection of citizens' health"*, Articles 13 and 30.

471 *Law "On prevention of HIV and AIDS'*, Articles 6-9 and Regulation of the Ministry of Health of Azerbaijan, No. 157 (23 October 1997).

472 Ministry of Health and Ministry of Defence, Joint Order No.562 (4 November 2005) and No. 342 (19 September 2005).

473 Government of Kyrgyzstan, "Professions, trades and posts which are subject to obligatory phyical examination," Resolution No. 296 (25 April 2006); *Law* "*On HIV/AIDS in the Kyrgyz Republic*" (13 August 2005), Article 8.

allowed to be employed in the occupations and positions included on this list. In Tajikistan, according to the information provided by the national expert group, some government departments and organizations mandate HIV testing of certain employees, such as military personnel and cadets, health care professionals and workers in the food industry. People living with HIV are not allowed employment in such professions. In Turkmenistan, if a person is HIV-positive he or she cannot hold positions which may involve work with blood, such as working as a surgeon, gynaecologist or lab assistant.[474]

In Uzbekistan, people living with HIV are prohibited from being employed in certain professions. These professions include health care positions as well as child-care positions or positions providing massage services or cosmetic services (e.g., hair styling).[475] According to the country report, HIV infection can be grounds for denying employment to military recruits and terminating employment for those in military service.

Right to education
In some project countries, people seeking enrolment to vocational training and higher education institutions are required to present a medical certificate, which includes a number of points (such as not being on the registry as a person who uses drugs or is dependent on drugs or alcohol, and may in certain cases include HIV). In Uzbekistan, according to the information presented by the experts, HIV test might be required for enrolment in the military and state security academies. In countries where HIV testing is required in order to be enrolled in some types of educational institutions such as a military academy, this provision constitutes denial of the right to education.

Right to freedom of movement
Many of the project countries deport non-citizens living with HIV. This practice is sometimes associated with — and made operational through — mandatory HIV testing of foreigners and stateless persons.

In Kazakhstan, all foreign citizens entering the country for longer than six months (including for permanent residence) must undergo a mandatory HIV test. A person with HIV will not be deported unless he or she avoids HIV testing or "preventative observation".[476] In Kyrgyzstan, the law mandates HIV testing for foreign citizens and stateless persons on arrival in the country and on an annual basis.[477] According to the country experts from Kyrgyzstan, in practice foreign citizens are subject to mandatory HIV tests only if Kyrgyzstan has signed an agreement to provide HIV certificates to that person's country of citizenship. The person is subject to deportation if they attempt to evade this test.

In Tajikistan, refugees and foreign nationals entering the country for work, study, permanent residence or other purposes for more than three months were previously subject to HIV testing. Until 2008, foreign citizens or stateless persons who tested HIV-positive were subject to deportation. In 2008, amendments to the national HIV law removed the deportation provision, although mandatory testing of foreigners remains in the law.[478]

In Turkmenistan, non-citizens who are HIV-positive are subject to deportation.[479] Non-citizens living with HIV will be denied a visa or a residence permit. Similarly, in Uzbekistan, the national HIV law provides that foreigners who are HIV-positive will be deported, while "HIV-free" certificates are required for obtaining a visa.[480] According to the Uzbekistan country report, the procedure of deportation is not regulated by the legislation; however, in practice territorial health bodies submit the information to the Ministry of Foreign Affairs, which arranges deportation.

Right to found a family
In Tajikistan, a government resolution lists the diseases that automatically prevent someone from adopting children; the list includes both HIV infection and drug dependence.[481] In both Kazakhstan and Kyrgyzstan, a similar list exists, prohibiting people with HIV (and people who are dependent on drugs) from adopting.[482] The law of Uzbekistan mandates testing before marriage for HIV, STIs, tuberculosis and drug dependence.[483] If testing determines that one or both parties planning to marry have one or more of the above conditions, registration of marriage is done after confirming awareness of both parties about the results of these tests. If testing reveals a condition that requires immediate treatment, the person is referred to treatment facilities.

474 Ministry of Health, Interdepartmental Instruction "On organising HIV prevention measures" (2000).

475 Ministry of Health, Ministry of Labour and Federation of Trade Unions of the Republic of Uzbekistan, Joint Resolution No 03/1 (6 December 1999).

476 Ministry of Health, Order "On HIV prevention in the Republic of Kazakhstan", Order No.10 (19 February 2007).

477 *Law "On HIV/AIDS in the Kyrgyz Republic"*, Law No. 149 (13 August 2005), Article 8; Kyrgyzstan, Government Resolution "Rules for medical examination to detect HIV, medical registration and observation of people with positive and ambiguous HIV tests in the Kyrgyz Republic", No. 296, 25 April 2006.

478 *Law "On counteracting HIV"*, Article 9.

479 *Law "On Migration"*, Articles 15 and 18.

480 *Law "On prevention of illnesses caused by human immunodeficiency virus (HIV)"*, Articles 6 and 12.

6.1.2 DISCRIMINATION AGAINST PEOPLE DEPENDENT ON DRUGS

Drug dependence as a health condition: legal provisions
All of the project countries have laws that define drug dependence as a disease.[484] For example, the country report for Azerbaijan observed that drug dependence is defined as a chronic disease under the *Law "On narcological service and control"*[485] and that those who are dependent on drugs might be considered as legally disabled (and able to access corresponding social security benefits), since the national *Law "On the prevention of physical disability, rehabilitation and social protection of the disabled"* could extend to cover those who are dependent on drugs.[486] This law defines disabled person as someone "limited in carrying out life functions, who needs social assistance and protection due to mental or physical defects with which he/she is born, or acquired." The limitation of capacity/ life functions is defined as "full or partial loss of the ability to take care of oneself, the capacity to move, orientation, the ability to communicate, the ability to control one's behaviour, and the ability to engage in employment." Among other provisions, this law protects people with a disability from discrimination. However, the expert group noted that neither the Cabinet of Ministers nor the Ministry of Social Security has yet prepared the appropriate regulations governing mechanisms of providing social assistance.

The legal recognition of drug dependence as a health condition in all of the project countries is accompanied by a range of restrictions on the rights of people with drug dependence; some of the restrictions amount to discrimination that is not justified. The *de jure* discrimination that needs to be examined and addressed in national laws also encourages and is accompanied by *de facto* discrimination. For example, according to the findings of the expert group from Kyrgyzstan, there is evidence of the following *de facto* infringements of the rights of people dependent on drugs: enforcement of compulsory testing and treatment; registration and associated loss of confidentiality and rights-limiting treatment; imposition of excessive administrative and criminal punishments; deprivation of parental rights; refusal to provide health, social, and other services; etc. The sub-sections that follow focus specifically on provisions in law or official policy that raise human rights concern, often because they infringe rights in ways that are unjustifiably broad.

Right to work and education
Many of the project countries formally prohibit people registered as dependent on drugs from working in certain professions and performing certain activities. This prohibition will last throughout the period during which the person remains on the registry (usually 3-5 years), regardless of whether the person is able to perform competently the inherent functions of the job.

In Azerbaijan, a Resolution of the Cabinet of Ministers established that people dependent on drugs would be restricted from employment of certain occupations and positions.[487] In Kazakhstan, being listed on the

481 Government of Tajikistan, Resolution No. 406 (1 October 2004).

482 *Law "On marriage and family"* (17 December 1998), Article 80, "*On the List of Diseases Preventing from Child, guardianship (Patronage), Foster Care"* implemented by Government Order No. 842 (24 July 1999); *Family Code of Kyrgyzstan*, Article 147; "*Provision on rules of transfer of children who have remained without care of parents, on adoption to citizens of the Kyrgyz Republic and foreign citizens*," No. 121 (22 February 2006).

483 Regulation "On Medical Testing of Persons Planning to Marry" [О медицинском обследовании лиц, вступающих в брак], Regulation No. 365, Annex 1 to the Resolution of the Cabinet of Ministers, "On Approving the Provision of Medical Testing of Persons Planning to Marry" (25 August 2003). Paragraph 4 indicates that persons entering marriage must undergo medical testing for psychological, narcological and venereal diseases, as well as tuberculosis and HIV/AIDS.

484 E.g., Kazakhstan's *Law "On narcotic drugs, psychotropic substances and precursors, and the measures to counteract illicit drug trafficking and abuse,"* Law No. 2002/15, Article 1(15); Tajikistan's *Law "On narcotic drugs, psychotropic substances and precursors"*(10 December 1999), Article 2.

485 *Law "On narcological service and control"*, Article 16.5.

486 *Law "On the prevention of physical disability, rehabilitation and social protection of the disabled"* (25 August 1998).

487 See: *Law "On narcological service and control"*, Article 24.4; Cabinet of Ministers of Azerbaijan, Resolution *"On the list of professions and positions, that are restricted for people with drug dependence and terms of restriction"* (last amended 13 February 2008); and Cabinet of Ministers of Azerbaijan, Resolution "*On medical examination of people in specific areas of work and profession, connected with high risk, in state narcological facilities,"* Resolution No. 145 (12 September 2002) and No. 018 (Febrary 2003).

drug treatment registry leads to prohibitions on entering certain professions.[488] In Kyrgyzstan, high school students enrolling in specialist high schools, such as military schools, must undergo a drug test,[489] and the country report also notes that some law enforcement bodies, drug control agencies and the Office of the Public Prosecutor oblige those applying for a job to undergo drug tests. In Tajikistan, a Decision of the Cabinet of Ministers prohibits those with drug dependence from certain forms of employment.[490] In Turkmenistan, persons registered for drug dependence treatment are prohibited from performing certain kinds of so-called "high risk" professions and activities.[491] This list is established by the Cabinet of Ministers and includes pilots, drivers, railway personnel and steeplejacks. According to the country report, a decision on the ineligibility of a person to work and undertake certain activities is made by a medical commission. People are kept on the registry for three years; registration can then be extended on re-examination. In Uzbekistan, also there is a long list of occupations that are prohibited for people with drug dependence.[492]

Right to found a family

In all of the project countries, drug dependence is a ground for denying child adoption. For example, in Kazakhstan, people who use drugs are denied the right to adopt children.[493] In Tajikistan, drug dependence figures on an official list of diseases that automatically prevent those who suffer from these diseases from adopting children (as noted above, the list also includes HIV).[494] In Uzbekistan, people who are registered as using drugs or dependent on them are formally prohibited from adopting children and drug use can be a reason for termination of adoption.[495]

Under the laws of all the project countries, alcohol or drug dependence can be an aggravating reason for depriving someone of parental rights in proceedings related to domestic child abuse or neglect. In Azerbaijan, the law specifies that in the case of detected child neglect or abuse, if the child's parents are chronic users of drugs or alcohol, they may be deprived of parental rights on this basis.[496] In the same situations, in Kazakhstan, parents are deprived of parental rights if they "are recognized in due order as a person abusing alcohol, drugs or substances".[497] According to the country report of Kyrgyzstan, dependence on narcotic drugs may be considered by courts as a valid basis for depriving someone of parental rights where there is reason to think there has been child abuse or neglect. In Tajikistan, in the case of child neglect or abuse, the *Family Code* provides for deprivation of parental rights if parents are dependent on alcohol or drugs.[498] Similarly, in cases of child neglect or abuse, in Turkmenistan, the *Code of Marriage and Family* states that persons who are alcoholic or dependent on drugs can be deprived of parental rights on this basis.[499] The same approach is used in Uzbekistan: people who are registered as using drugs or dependent on them can be deprived of their parental rights by court ruling.[500]

Driving licences

In all of the project countries, a person has to undergo a physical examination (including a drug test) or provide a "drug free" certificate in order to be issued a driver's licence. In Kazakhstan, people registered in drug treatment facilities are restricted from holding a driver's licence.[501] In Kyrgyzstan, applicants for a drivers licence must pass a physical examination which includes a drug test.[502] In Tajikistan, a Decision of the Cabinet of Ministers prohibits those with drug dependence from holding a driver's licence.[503] In Turkmenistan, those who are registered as using drugs or dependent on them are not permitted to hold a driver's licence.[504] In Uzbekistan, a person who wants to get a driver's licence requires a "drug-free" certificate from a narcological centre.[505]

Right to vote

In Turkmenistan, if a court considers that a person using drugs "puts his family in a grave financial situation", then the court can revoke that person's legal capacity. One of the consequences of this finding is that the person loses the right to vote.[506] Similar provisions exist in all the project countries.[507]

Freedom of movement

In Turkmenistan, the *Law "On migration"* establishes that where a person without citizenship is drug dependent, this can be the basis for cancelling or refusing to issue a visa or residence permit.[508]

Involuntary HIV testing of people who use drugs

In many project countries, the national HIV law or subsidiary regulations specify mandatory HIV testing for vulnerable groups — people with drug dependence are generally one of the groups singled out for this often involuntary medical procedure. In Azerbaijan, according to an Order of the Ministry of Health, people dependent on drugs are subject to mandatory HIV testing (along with tuberculosis patients, STI patients, pregnant women and people in prison).[509] According to the country report from Tajikistan, regulations request mandatory HIV testing of people dependent on drugs, among others (though the latest governmental decree explicitly requires their informed consent for testing).[510] In Turkmenistan, the country experts report that HIV testing is involuntary for a variety of population groups, including people dependent on drugs and those who are registered for treatment for drug dependence.[511] The vague and unelaborated language of laws and ministerial instructions regulating HIV testing and especially those related to testing of vulnerable groups opens the door for discrimination and other human rights violations.

6.2 RATIONALE FOR LEGISLATIVE AND POLICY REFORM TO ADDRESS DISCRIMINATION

Discrimination against people living with HIV, or those presumed to be living with HIV, violates fundamental human rights, including the right to be free from discrimination. Article 26 of the ICCPR guarantees that "[a]ll persons are equal before the law and are entitled without any discrimination to the equal protection of the law. In this respect, the law shall prohibit any discrimination and guarantee to all persons equal and effective protection against discrimination on any ground such as race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status."[512] The United

488 Government of Kazakhstan, Resolution "*On the list of medical and psychological counter- recommendations for certain professions and jobs connected with high risk*", Resolution No. 668 (18 June 2002); Ministry of Health, "Instruction on mandatory preventive and periodical medical check ups of workers, that are influenced by harmful, dangerous and unfavourable employment risks and determination of professional capacity", Instiruction No. 243 (12 March 2004), paras 12.4 and 13.

489 See, e.g., "Instruction on physical examination of students of military lyceums and the candidates seeking admission to the lyceum," Instruction No. 199 (9 September 2000).

490 *Law* "*On narcological assistence*", Law No. 67 (8 December 2003), Article 8.

491 *Law "On narcotic drugs, psychotropic substances, precursors and mesures of counteraction of their trafficking"*, Article 53.

492 See Ministry of Health/ Ministry of Labor and Social Protection/ Trade Union Federation Council of Uzbekistan, Resolution "On Establishing a List of Professional Activities Restricted for People with Drug Dependence", Joint Resolution No. 8/46/14-10 (7 April 2003). .

493 Government of Kazakhstan, *List of Diseases Preventing Child Adoption, Guardianship and, Foster Care*, Resolution No.842 (24 June 1999).

494 Government of Tajikistan, Resolution No. 406 (1 October 2004).

495 Ibid., Articles 152 and 169.

496 Azerbaijan's *Family Code*, Law No. 781-2 (28 December 1999), Article 64.

497 *Law* "*On Marriage and Family*", Law No.321-I (17 December 1998), Article 67.

498 Tajikistan's *Family Code*, Article 69.

499 Turkmenistan's *Code on Marriage and Family*, Articles 70 and 115.

500 *Family Code of Uzbekistan*, Article 79.

501 Ministry of Health, Order No.243 (12 February 2004).

502 Kyrgyzstan, "Regulation for examinations, issuance to citizens of driver's licenses and the admission of drivers to driving vehicles," No. 420 (4 August 1999).

503 Government of Kazakhstan, Ressolution "On the list of medical and psychological counter- recommendations for certain professions and jobs connected with high risk", Resolution No. 668 (18 June 2002), Ministry of Health, "Instruction on mandatory preventive and periodical medical check ups of workers, that are influenced by harmful, dangerous and unfavourable employment risks and determination of professional capacity", Instruction No. 243 (12 March 2004), paras 12.4 and 13.

504 Ministry of the Interior, Order No. 138 (26 July 2000), para 2.2.

505 Ministry of Health, "On improvement of the procedure of undergoing pre-employment preventive and current medical exam" (6 June 2000).

506 See *Law* "*On narcotics, psychotropic substances, precursors and counteraction measures to their illegal circulation*", Article 53, and Turkmenistan's *Civil Code*, Articles 26(1) and 27(1).

507 E.g., see Uzbekistan's *Civil Code*, Article 31.

508 *Law* "*On migration*", Article 15.

509 Ministry of Health, "*Methodical instruction on mandatory HIV testing for people who inject drugs*", No. 02/19-1101 (26 May 1997); Ministry of Health, Order No. 157 (23 October 1997).

510 Also covered by these regulations are pregannt women, people with sexually transmissabel diseases, prisoners, people with tuberculosis, military recruits and military personel.

511 Other groups include persons infected with tuberculosis, hepatitis, STDs; prisoners; sex workers; foreign citizens if their stay in territory of Turkmenistan exceeds 3 months; pregnant women; newborns if the mother is HIV-positive or based on clinical indications; workers in public health services, if their work is connected with blood.

512 See also *International Covenant on Civil and Political Rights*, Article 2. All of the project countries have either ratified or acceded to the ICCPR. Freedom from discrimination is enshrined in other international and regional human rights instruments: e.g., the *Universal Declaration on Human Rights* (Article 2); *International Covenant on Economic, Social, and Cultural Rights* (ICESCR) (Article 2); *Convention on Elimination of All Forms of Discrimination Against Women* (Article 12); the *Convention on the Rights of the Child* (Article 2); and *European Convention for the Protection of Human Rights and Fundamental Freedoms* (Article 14).

Nations Commission on Human Rights has repeatedly declared that the term "other status" in non-discrimination provisions in international human rights treaties "should be interpreted to cover health status, including discrimination on the basis of HIV/AIDS status, actual or presumed."[513]

Notwithstanding the illegal status of some drugs, people who use those drugs have human rights and are entitled to protection of their rights. In reality, the enjoyment of human rights is undermined by the social stigmatisation attached to drug use and the resulting discrimination against people who use drugs.

Drug dependence is a chronic and relapsing disease.[514] In some jurisdictions, where a person is deemed to be drug-dependent, he or she may be able to draw on additional legislative protections. For example, as mentioned earlier, according to the country report from Azerbaijan, dependence on a drug is defined as a chronic disease and might be considered as a category of a disability (and hence allow the disabled person to be paid social benefits).[515] In some countries (other than those participating in this project), protection from discrimination based on drug dependence is afforded where legislation recognizes drug dependence under the definition of "disability" or "health status" for the purposes of anti-discrimination law. In these jurisdictions, people who are, or are perceived to be, drug-dependent enjoy protection from discrimination based on disability or health status in employment and in the provision of goods, services, facilities or accommodation.[516]

According to principles well established in international human rights law, limitations or infringements on human rights may only be justified in accordance with clear standards.[517] One key principle is that of non-discrimination, including based on health status. Treatment that denies a right or benefit to someone, or deprives him or her of a such a right or benefit, based solely on health status, requires adequate justification based on the circumstances of the case. Blanket prohibitions or disentitlements (e.g. of all persons with HIV), will rarely be justifiable.

In the 2001 *Declaration of Commitment on HIV/*AIDS, member states of the UN General Assembly made a commitment to:

> enact, strengthen or enforce, as appropriate, legislation, regulations and other measures to eliminate all forms of discrimination against and to ensure the full enjoyment of all human rights and fundamental freedoms by people living with HIV/AIDS and members of vulnerable groups… and develop strategies to eliminate stigmatization and marginalization related to the epidemics.[518]

In 2006, member states of the UN General Assembly committed to intensifying these efforts.[519]

The UNAIDS/OHCHR *International Guidelines on HIV/AIDS and Human Rights* recommend that:

> General anti-discrimination laws should be enacted or revised to cover people living with asymptomatic HIV infection, people living with AIDS and those merely suspected of HIV or AIDS. Such laws should also protect groups made more vulnerable to HIV/AIDS due to the discrimination they face. Disability laws should also be enacted or revised to include HIV and AIDS in their definition of disability.[520]

The *International Guidelines* go on to state that anti-discrimination legislation should provide protection from discrimination in both the public and private sectors and include coverage of direct and indirect discrimination.[521] Effective legal protection includes the capacity to invoke and enforce those laws and regulations through the courts, human rights tribunals, professional regulatory bodies and the like. To ensure effective enforcement of legal provisions, the *International Guidelines* recommend that states ensure:

> Independent, speedy and effective legal and/or administrative procedures for seeking redress, including such features as fast-tracking for cases where the complainant is terminally ill, investigatory powers to address systemic cases of discrimination in policies and procedures, ability to bring cases under pseudonym and representative complaints, including the possibility of public interest organizations bringing cases on behalf of people living with HIV.[522]

The UN Commission on Human Rights repeatedly urged states to take all necessary steps to ensure the respect, protection and fulfilment of HIV-related human rights as contained in the *International Guidelines*, including taking all necessary measures to eliminate stigmatization and discrimination against those infected and affected by HIV.[523]

Particular populations who already suffer from a lack of human rights protection and from discrimination or who are marginalized by their lack of legal status are often disproportionately vulnerable to HIV infection. The *International Guidelines* recognize people who use drugs as one such group.[524] The *International Guidelines* recommend that "States' legislation, policies, programmes, plans and practices should include positive measures to address factors that hinder the equal access of vulnerable individuals and populations to prevention, treatment, care and support…"[525]

In the vast majority of cases throughout the project countries, the protection against discrimination guaranteed by Constitutional provisions and articles in various laws (such as the HIV law, the disability law or the health law) is of limited significance. In broad terms, the existing non-discrimination law of the project countries (whether in the Constitution or other laws) correctly reflects the position in international law and policy guidance. However, the country reports reveal a range of discriminatory laws (and on occasion practices) that contribute to the widespread and systematic discrimination and stigmatisation faced by people living with HIV and people who use drugs. In the majority of cases, these discriminatory laws and policies are framed as exceptions to non-discrimination law principles. This is of serious concern, as national efforts to reduce discrimination and stigmatisation against people who live with or are vulnerable to HIV among society in general will be undermined when national laws and policies formalise such discrimination.

Not all differential treatment will constitute discrimination. The UN Human Rights Committee has noted that differential treatment will not constitute unlawful discrimination if the criteria for such differentiation are reasonable and objective and if the aim is to achieve a legitimate purpose under the ICCPR.[526] The reasonableness of the difference in treatment must be determined by factors such as whether it corresponds to a pressing and substantial objective, whether it is rationally connected to that objective, whether it impairs rights as little as possible and whether it is proportionate to that objective.[527]

> "Public health is most often cited by States as a basis for restricting human rights in the context of HIV. Many such restrictions, however, infringe on the principle of non-discrimination, for example, when HIV status is used as the basis for differential treatment with regard to access to education, employment,

513 UN Commission on Human Rights, *The protection of human rights in the context of human immune deficiency virus (HIV) and Aquired Immune Deficiency Syndrone (AIDS*), Resolutions 1999/49 (27 April 1999), 1995/44 (3 March 1995), 1996/43 (19 April 1996), and 2004/26 (16 April 2004).

514 See National Institute for Drug Abuse (NIDA) [USA], *Principles of Drug Addiction Treatment: A research-Based Guide*, NIH Publication No. 99-4180, October 1999. WHO recognises drug dependence as a chronic, relapsing medical condition: WHO, *Neuroscience of Psychoactive Substance Use and Dependence* (Geneva: WHO, 2004), pp. 7, 32-34.

515 *Law "On narcological servcie and control"*, Article 16.5.

516 See, for example, *Canadian Human Rights Act* (R.S., 1985, c. H-6): section 25 of the Act defines disability as any previous or existing mental or physical disability and includes previous or existing dependence on alcohol or a drug; see also the *Disability Discrimination Act 1992* [Australia]: the definition of "disability" is broad enough to encompass dependence on alcohol or a drug.

517 UN Economic and Social Council, *Siracusa Principles on the Limitation and Derogation Provisions in the International Covenant on Civil and Political Rights*, UN Doc. E/CN.4/1985/4, Annex (1985).

518 United Nations General Assembly, *Declaration of Commitment on HIV/AIDS*, UNGA Resolution S-26/2 (26 June 2001), UN Doc. A/RES/S-26/2, para 58.

519 United Nations General Assembly, *Political Declaration on HIV/AIDS*, UNGA Resolution 60/262 (2006), UN Doc. A/RES/60/262, para 29.

520 See *International Guidelines*, para 22(a).

521 Ibid. States should also be guided by *Taking action against HIV: A Handbook for Parliamentarians*, which states that "strengthen legislation, regulations and other measures to eliminate all forms of discrimination against people living with HIV and members of key at-risk populations": IPU/UNAIDS/UNDP, *Taking action against HIV: A Handbook for Parliamentarians*, No. 15 (2007), p. 89.

522 *International Guidelines*, para 22(a)(iii).

523 See, e.g., UN Commission on Human Rights, *The protection of human rights in the context of human immunodeficiency virus (HIV) and acquired immune deficiency syndrome (AIDS),* Resolution 1999/49 and Resolution 2001/51.

524 *International Guidelines*, para 31.

525 *International Guidelines*, para. 31.

526 See UN Human Rights Committee, General Comment 18: Non-discrimination (1989), para. 13, online via http://www2.ohchr.org/english/bodies/hrc/comments.htm.

527 Ibid., and see also: UN Economic and Social Council, *Siracusa Principles on the Limitation and Derogation Provisions in the International Covenant on Civil and Political Rights*, UN Doc. E/CN.4/1985/4, Annex (1985). UNAIDS has developed a protocol designed to assist states determine whether laws, regulations, procedures, or practices are discriminatory against people living with HIV: UNAIDS, *Protocol for the identification of discrimination against people living with HIV*, 2000.

health care, travel, social security, housing and asylum. The right to privacy is known to have been restricted through mandatory testing and the publication of HIV status and the right to liberty of person is violated when HIV is used to justify deprivation of liberty or segregation. Although such measures may be effective in the case of diseases which are contagious by casual contact and susceptible to cure, they are ineffective with regard to HIV since HIV is not casually transmitted. In addition, such coercive measures are not the least restrictive measures possible and are often imposed discriminatorily against already vulnerable groups. Finally, and as stated above, these coercive measures drive people away from prevention and care programmes, thereby limiting the effectiveness of public health outreach. A public health exception is, therefore, seldom a legitimate basis for restrictions on human rights in the context of HIV."[528]

A similar balancing process is required by the Constitutions of the report countries. Rights and freedoms guaranteed by a state can only be limited by law where necessary for very specific objectives. For example, according to the Constitution of Kazakhstan, certain rights cannot be restricted in any circumstances. Other rights can only be restricted "to the extent necessary for protection of the constitutional system, defence of the public order, human rights and freedoms, health and morality of the population."[529]

In practice, the restrictions on the rights of people living with HIV and people who are dependent on drugs are frequently justified by broad and vague notions of "the public interest". For example, with respect to people living with HIV, "public interest" concerns may be expressed as the desire to reduce the risk of transmission to people who are not infected. With respect to people dependent on drugs, the "public interest" objective may be related to concerns about workplace performance or workplace safety issues. However, on closer examination, the restrictions that are common in the laws and policies across the project countries do not stand up to scrutiny. Far too often in the laws and policies of the report countries, the limitations on the rights of people living with HIV and people who are dependent on drugs are either not rationally connected to their objective or do not impair human rights as little as possible.

Right to work

Prohibitions on people living with HIV from certain forms of employment are manifestly unjustified. HIV is not casually communicable. In relation to discrimination in the workforce, the ILO's *Code of Practice on HIV/AIDS and the world of work* states that:

In the spirit of decent work and respect for the human rights and dignity of persons infected or affected by HIV/AIDS, there should be no discrimination against workers on the basis of real or perceived HIV status. Discrimination and stigmatization of people living with HIV/AIDS inhibits efforts aimed at promoting HIV/AIDS prevention.[530]

HIV testing as a condition of employment is rarely justifiable, yet is currently found in the legislation of a number of the project countries. However, it is incorrect to assume that a worker is incapable of performing the duties of certain occupations simply because he or she has HIV; therefore, blanket exclusions from holding certain positions are unjustifiable discrimination. Decisions about a person's competence to perform work should be made on an individual basis, not based on HIV status. International guidance in this area establishes that:

The right to work entails the right of every person to access to employment without any precondition except the necessary occupational qualifications. This right is violated when an applicant or employee is required to undergo mandatory testing for HIV and is refused employment or dismissed or refused access to employee benefits on the grounds of a positive result. States should ensure that persons living with HIV are allowed to work as long as they can carry out the functions of the job. Thereafter, as with any other illness, people living with HIV should be provided with reasonable accommodation to be able to continue working as long as possible and, when no longer able to work, be given equal access to existing

528 *International Guidelines*, para. 105.

529 Constitution of Kazakhstan, 30 August 1995, Articles 14(2) and 39. Interestingly, the prohibition on discrimination "for reasons of origin, social, property status, occupation, sex, race, nationality, language, attitude towards religion, convictions, place of residence or any other circumstances" is listed as one of the rights not to be restricted in any circumstances.

530 ILO, *An ILO Code of Practice on HIV/AIDS and the world of work*, 2001, p. 3.

sickness and disability schemes. The applicant or employee should not be required to disclose his or her HIV status to the employer nor in connection with his or her access to workers' compensation, pension benefits and health insurance schemes. States' obligations to prevent all forms of discrimination in the workplace, including on the grounds of HIV, should extend to the private sector.[531]

Indeed, the ILO recommends that "HIV/AIDS screening should not be required of job applicants or persons in employment" and that workers who come into contact with human blood and other body fluids should receive training in infection control procedures in the context of workplace accidents and first aid, including universal procedures.[532] Around the world, courts have repeatedly held that restrictions on people living with HIV from employment (e.g. in armed forces, airlines, private clubs, public sector associations) are discriminatory.[533]

Similarly, blanket prohibitions on people who are dependent on drugs from certain forms of employment are too broad, given that there are no individual determinations of a person's inability to perform the inherent requirements of the job. Essentially, the proportionality of the restrictions is unsubstantiated. The effects of drug dependence will vary widely among individuals. While there may be certain circumstances where someone who is dependent on drugs is unable to perform the inherent requirements of a particular job, such blanket restrictions unnecessarily restrict those people who are dependent on drugs but may be perfectly able to perform this work.[534] Further, people who are dependent on drugs are frequently retained on state registries for a set period of time (generally 3-5 years, depending on the country) regardless of their response to treatment. Clearly, while there may be circumstances where a person who is dependent on drugs is unable to perform the inherent requirements of certain jobs, this should be determined on a case-by-case basis. The automatic assumption that all people registered as drug dependent are unable to perform these jobs is discriminatory.

Drug testing *before* employment (or enrolment in an educational institution) is also unjustified discrimination based on health condition (in addition to violating privacy rights, bodily security and dignity). Requiring testing for drug use *during* employment may only be potentially justifiable in quite limited circumstances, such as limiting testing to positions that are safety-sensitive and then only in cases where there are reasonable grounds to suspect impairment or, possibly, random drug testing of persons returning to work after receiving drug dependence treatment. Such issues have been litigated extensively in a number of jurisdictions and tribunals have succeeded in articulating how legitimate interests in ensuring safety in the workplace or of the public can be protected while not adopting rules that are unjustifiably overbroad and deem all persons who use drugs as barred from employment (or an educational institution). These more nuanced, less categorical approaches could be potentially useful to legislators and policy-makers in crafting reforms along the lines of those recommended in the individual country reports.

Right to found a family

Similarly, an automatic assumption that people who are dependent on drugs or who are living with HIV cannot be good parents is discriminatory. As noted above, both HIV-positive status and drug dependence can also affect familial rights and responsibilities under the laws of the project countries, such as being automatically barred from adopting a child – and in the case of deprivation of parental rights, drug or alcohol dependence is explicitly singled out as an aggravating factor in many countries' legislation, akin to wilful harm to a child, for possibly depriving a person of their custody or other rights vis-à-vis their child. But such categorical prohibitions are troubling as a matter of human rights, as is the heightened risk of losing their children to which people with drug dependence are exposed by such legislative singling-out.

531 *International Guidelines*, para. 149.

532 See ILO, An ILO Code of Practice on HIV/AIDS and the world of work (2001), p. 4 and 14. Universal precautions consist of careful handling and disposal of sharps (needles or other sharp objects); hand-washing before and after a procedure; use of protective barriers – such as gloves, gowns, masks – for direct contact with blood and other body fluids; safe disposal of waste contaminated with body fluids and blood; proper disinfection of instruments and other contaminated equipment; and proper handling of soiled linen.

533 See, for example, *Canada (Attorney General) v. Thwaites* [1994] 3 FC 38 (Canada), *Hoffmann v. South African Airways* [2000] 11 BCLR 1235 (South Africa), *XX v. Gun Club Corporation et al.* Constituional Court Judgemnt No. SU-256/96 [1996] (Colombia). For descriptions of these and other cases, see Canadian HIV/AIDS Legal Network & UNAIDS, *Courting Rights: Case studies in litigating the human rights of people living with HIV*, UNAIDS Best Practice Collection (2006).

534 For a discussion of how restrictions on the rights of drug users violate the principle of non-discrimiantion in the case of the Russian Federation, see Human Rights Watch, *Rehabilitation Required: Russia's Human Rights Obligation to Provide Evidence-based Drug Dependence Treatment* (2007).

Being HIV-positive cannot correctly be considered something that automatically makes a person unfit or unsuitable to become a parent or continue parenting his or her child. Similarly, it is not warranted to equate, almost automatically, a person's drug use or dependence with the wilful mistreatment of children. Therefore, the law should be clearly stated, and clearly interpreted, so as to avoid depriving parents of their children solely on the basis of such a diagnosis – any such deprivation should require proof of poor treatment or real risk of poor treatment of those children, and the law's interpretation and application should not be based on assumptions reflecting stigma or misinformation about people who use drugs. It will be the very rare case in which denying certain rights or benefits to entire classes of persons based on their health status (e.g., diagnosis with HIV infection or drug dependence) will be justifiable. Rather, determinations of parental rights should be considered by an individual assessment and governed by the over-riding consideration of the best interests of the child, rather than based on inaccurate, generalized assumptions about a person's capacity to be a suitable parent based on health status.

Right to freedom of movement

Some of the country reports revealed that non-citizens who are living with HIV are to be deported or denied visas or permanent residence. It is true that no one has a right to enter a country other than his or her country of nationality (except refugees, who have a right to seek asylum from persecution). However, where a state does provide a benefit or entitlement – such as a long-term visa or a residence permit – it must not restrict such a benefit or entitlement in a discriminatory manner. Blanket denial of entry or residence based on HIV status is such discrimination. According to the *International Guidelines*:

> There is no public health rationale for restricting liberty of movement or choice of residence on the grounds of HIV status. According to the current international health regulations, the only disease which requires a certificate for international travel is yellow fever... Therefore, any restrictions on those rights based on suspected or real HIV-status alone, including HIV screening of international travellers, are discriminatory and cannot be justified by public health concerns.[535]

The ostensible objective of the exclusion of long-term immigrants with HIV may be to protect society from threats to public health in the form of contagious diseases or to protect the health-care system from "excessive" demand. However, testing immigrants for HIV and automatically excluding all those known to be HIV-positive is not *rationally connected* to these objectives.

As noted above, persons living with HIV are not a threat to public health simply because of their illness (HIV-infection) is not contagious through casual contact. Exclusion of immigrants living with HIV will not prevent the spread of HIV domestically. By claiming that immigrants living with HIV are a threat to public health by virtue *only* of their HIV status and regardless of their behaviour, people with HIV will generally be stigmatized as dangers to public health and safety. Not only does such stigmatisation inflict hardship on people living with HIV, but it may also discourage members of the population from voluntarily choosing to be tested for HIV or to seek information on HIV prevention or care. In this way, this provision may indeed undermine the purported public health objective of reducing rates of HIV transmission. Similarly, a blanket removal of all immigrants on the grounds of "excessive" demand on public health costs fails to recognise that the actual medical costs of treatment will depend on each person and the progression of his or her infection, and also generally leaves little room for considering that person's contributions to the country of residence.

In addition, even if excluding all immigrants with HIV were an effective way to prevent spread of the virus within the population, it is *not the way that least impairs* the rights of individuals living with HIV. Indeed, in certain circumstances, to test individuals for HIV without also offering the possibility of treatment or counselling may amount to cruel, inhuman or degrading treatment.[536]

535 *International Guidelines*, para 127.

536 Coercing a person into knowing his or her HIV-positive status without providing treatment, care or support and forcing him or her to return to their country (which may also not provide care, treatment or support) could involve considerable mental and physical hardship for that person. Such hardship may amount to cruel, inhuman or degrading treatment, which is prohibited by Article 7 of the ICCPR. See G.S. Goodwin-Gill, "AIDS, HIV, Migrants and Refugees: International Legal and Human Rights Dimensions," in M. Haour-Knipe & R. Rector, eds., *Crossing Borders: Migration, Ethnicity, and AIDS* (London: Taylor & Francis, 1996), pp. 50-69 at pp. 53-54.

6.3 RECOMMENDATIONS FOR POLICY AND LEGISLATIVE REFORM TO ELIMINATE DISCRIMINATION

Governments have a crucial role to play in providing an effective legal framework in which individuals can assert their rights. As the above analysis shows, the laws and policies of the project countries are marked by provisions that discriminate against people living with HIV or people particularly vulnerable to infection. As a general matter, it is recommended that the unnecessary and/or overly-broad restrictions on the rights of people living with HIV or people who are dependent on drugs identified above be carefully reconsidered, with a view to their removal or redrafting.

Recommendation 49: Ensure explicit and adequate protection in the law against discrimination based on HIV status and drug dependence

The steps necessary to ensure the law provides clear protection against discrimination to both people living with HIV and people with drug dependence will vary from country to country; specific recommendations can be found in each of the country reports in Part II. However, the following steps, drawn in part from the recommendations of various national expert groups, should be considered, as may be relevant to the country in question:

- **Strengthen existing legislative protections against HIV-based discrimination where there are gaps:** Generally, all the project countries have some legislative prohibitions against discrimination based on HIV status, albeit in a somewhat piecemeal fashion. In some cases, national expert groups have identified a need for strengthening current law to address discrimination in specific contexts. For example, the country experts from Azerbaijan and Tajikistan put forward a recommendation to introduce stricter provisions prohibiting discrimination based on HIV status into the national law on HIV.

- **Introduce legal protection against discrimination based on drug dependence:** It could be argued, perhaps more strongly in some of the project countries than others, that existing anti-discrimination provisions encompass discrimination against people with drug dependence. Yet there is certainly a need for legislative action on this front, as recognized by several of the national expert groups. For example, in Kyrgyzstan, the experts recommended the elimination of "discriminating provisions in the legislation concerning persons who use drugs and persons living with HIV, including in the penitentiary system" and the adoption of "corresponding regulatory legal acts with a provision protecting persons on the basis of the present or alleged drug dependence from discrimination." In Uzbekistan, the country experts recommended that the existing national law on drugs (or the special law on treatment of drug dependence, that they also recommended be enacted) should include a provision establishing that discrimination based on drug use is illegal. They consider that "formalization of such a provision in this law will help overcome stigmatization of drug users." Similarly, the group of experts from Azerbaijan developed recommendation to introduce anti-discrimination provisions protecting persons with actual or perceived drug dependence from discrimination.

- **Where necessary, recognize both HIV infection and drug dependence as disabilities:** As a result of HIV-related stigma, people living with HIV are subjected to discrimination, often partly because of their actual or perceived disability arising from their infection. Recognition of HIV infection and of drug dependence as disabilities can mean, in at least some jurisdictions, that legal provisions prohibiting discrimination based on disability are applicable; it could also give people with HIV access to additional guarantees and benefits such as social security depending on clinical state. Where it is not already the case in the national law, project countries should clearly recognize HIV infection as a disability for these two purposes under the law. The same concept is applicable to drug dependence. For example, in Azerbaijan the national expert group noted that although drug dependence is defined as a chronic disease and those found to be drug dependent theoretically might be eligible for social security benefits, the required regulation to bring this provision into effect from the Cabinet of Ministers or Ministry of Social Protection is not in place. This oversight should be remedied.

Recommendation 50: Revise existing legal instruments to eliminate unjustified restriction or denial of rights to people who use drugs and people living with HIV

As a general recommendation, countries should revisit and repeal blanket rules, whether found in statutes or in other official instruments such as decrees, resolutions, orders or instructions, that restrict rights based on health status such as HIV infection or drug dependence. As the national expert group from Turkmenistan recommended, legislation restricting the rights of people dependent on drugs (including the prohibition on being engaged in certain professional activities) should be reviewed, and experiences of other countries should be studied. The Tajik expert group similarly recommended introducing amendments to remove provisions that deny rights to all people who use drugs as well as people living with HIV. As the groups from both countries observed, each restriction imposed should be shown to be strictly necessary. In particular, given the provisions identified above, action should be taken to address the following:

- **Remove unjustified discrimination in employment and educational institutions:** For the reasons outlined above, in all but the most exceptional circumstances, there is no justification for denying employment in certain occupations or enrolment in an educational institution based on a person's HIV status. Therefore rules mandating HIV testing as a condition of employment or enrolment, and the inclusion of HIV on lists of diseases with which people cannot occupy certain jobs, should be abolished. Similarly, drug testing as a condition of employment (or enrolment) is not justified absent exceptional circumstances. Therefore, several national expert groups recommended repealing very broad, general provisions allowing for employees to be tested for drugs in the workplace, while legitimately maintaining drug testing for certain "high-risk" occupations. In Kazakhstan, the country experts recommended that the system of registration of people who use drugs should be evaluated, and that the system be reformed in ways that better protect the rights of people who use drugs (such as removal of prohibitions on holding certain positions).

- **Remove unjustified discrimination in family relations:** Amend provisions in codes governing family relations to ensure that stereotypical assumptions or misinformation about people with drug dependence (or HIV) are not the basis on which people are denied or deprived of parental rights. Instead, require that there be some reasonable grounds to believe children are at risk of harm or neglect and that decisions be made based on individualized assessments of the best interests of the child or children.

- **Remove discriminatory immigration policies:** As noted, all the project countries maintain some form of discriminatory treatment of foreigners (and sometimes stateless persons) in their law and policy regarding HIV infection, including mandatory HIV testing and such practices as denial of visa/entry, restrictions on residence, and/or deportation of those who test HIV-positive. Such blanket rules are unjustifiably discriminatory, and need to be repealed. Recent amendments in Tajikistan (2008), which eliminated legislative provisions for deportation of foreigners who test HIV-positive, is a step in the right direction, although further reform is needed to repeal mandatory HIV testing of foreigners. As one of the country expert teams recommended: "changes should be introduced into the legislation of the Republic of Uzbekistan for provisions on compulsory HIV testing of foreign nationals and deportation of foreigners with HIV, since these provisions are discriminatory and unjustified." The same reasoning and recommendation applies elsewhere.

Eliminate involuntary HIV testing of people with drug dependence (and other groups): As noted, legislation or other official policies imposing or authorizing involuntary HIV testing of people with drug dependence is discriminatory; it singles out a group of people based on their health status for infringements of their rights to privacy and bodily integrity. Such discrimination is not justified and should be eliminated in all countries where it exists. The laws and ministerial instructions should be amended/elaborated in such a way that they explicitly prohibit any coercion in HIV testing while at the same time ensure provision of full confidentiality and informed consent as well as prescribing measures to enforce human rights protection.

7. RECOMMENDATIONS FOR UN AND OTHER DEVELOPMENT AID ORGANIZATIONS

Recommendation 51: Emphasize human rights of vulnerable groups

In conducting any work relating to HIV and drugs, the UN and other international organisations should emphasise the importance of protecting human rights, especially of people who might be at higher risk of contracting HIV, including people who use drugs, sex workers, prisoners, and men who have sex with men. The UN and other international organisations should put greater emphasis on and weight behind its own recommendations regarding HIV and human rights, such as in the *International Guidelines on HIV/AIDS and Human Rights*, and emphasise the importance of following those recommendations for implementing a successful response to the epidemic.

Recommendation 52: Support civil society in the promotion of human rights of groups vulnerable to HIV and of evidence-based measures for HIV prevention, care, treatment and support

When laws, policies and programmes reflect and contribute to the marginalization of individuals and communities -- such as on the basis of HIV status, drug use, sex work or sexual orientation -- thereby exacerbating their vulnerability to HIV and lack of access to HIV-related care, it is all the more important and necessary to ensure civil society representing these groups can play a meaningful role in shaping the response.

Therefore, UN and other international organisations must support civil society groups of people living with HIV and from marginalized, vulnerable communities in the exercise of fundamental human rights, such as freedom of expression and association, that are necessary for this even to be possible.

Recommendation 53: Emphasize the principal role of the state in implementing the right to health

Any work done by the UN with or in a country should clearly emphasize the role of the state as the main and ultimate duty-bearer for respecting, fulfiling and protecting the right to the highest attainable standard of health for all people living on its territory, without discrimination on any ground.

Recommendation 54: Ensure attention to a broader range of human rights concerns that affect HIV prevention and treatment

While assisting governments to contain the HIV epidemic through policy development and institutional capacity-building, the UN and other international organizations should not limit themselves to a narrow focus solely on policies directly related to the provision of HIV services, but should attend to the broader range of structural or contextual factors that affect access to HIV-related services and the outcomes of HIV prevention and treatment efforts, by addressing such issues as:

- discrimination (based on health status, civil status, ethnicity, gender, age, etc);
- compulsion/coercion in the health care context (including with respect to HIV- and drug-testing, treatment of HIV-infection, drug dependence, TB, STIs); and
- confidentiality and other patients' rights (such as giving informed consent for medical interventions, the exchange of information between health care establishments and law enforcement bodies etc.).

Recommendation 55: Support accurate implementation of legislation, including through training of government officials, law enforcement and correctional officers, and health care providers

This legislative review demonstrated that often there is inaccurate implementation of existing national legislation or lack of its enforcement (e.g. low enforceability of anti-discrimination legislation). It is recommended that international organisations in their work with the governments emphasise the importance of accurate implementation of human rights and other legislation in ways that seek to respect, protect and fulfil human rights. This could be done by means of conducting trainings for government officials and bodies enforcing the realization of laws (e.g., Offices of Prosecutors-General, Constitutional Courts, etc.), including on the issues of human rights, anti-discrimination and respect for vulnerable groups.

Recommendation 56: Support the strengthening of anti-discrimination legislation and its implementation

Despite the existence on paper of legal protection against discrimination, the assessment done for this project showed that in all project countries these provisions are hardly enforceable, including because of the lack of enforcement mechanisms. It is recommended that international organisations assist countries in strengthening not only their formal legislation against discrimination but also the mechanisms for enforcing that legal protection and securing an effective remedy in cases where discrimination is established.

Recommendation 57: Facilitate development of balanced national drug policy

International organisations should help countries develop balanced drug policies, including attention to harm reduction rather than simply drug demand and supply reduction. In participating in the process of developing these policies, international organisations should pay attention to facilitating a shift to treating drug dependence as a public health problem, and not as a law enforcement problem.

Recommendation 58: Help countries develop standards of drug dependence treatment

The analysis done for this project showed that the project countries have outdated structures and standards of drug dependence treatment, which consequently are ineffective. International organisations, including WHO, should help countries in developing up-to-date standards of drug dependence treatment, based on scientific evidence and informed by best international practices, including respect for human rights standards. In particular, international organisations are encouraged to initiate and participate in the public discussion regarding limiting (or discontinuing entirely) the registration of people who use or are dependent on drugs, the unjustifiable violations of patient confidentiality that often accompany or follow registration, and the overly broad resort to compulsory treatment of drug dependence (often with inadequate methods), encourage the introduction and scale up of the opioid substitution therapy, and state-funded rehabilitation services.

Recommendation 59: Support legislative and policy reform to strengthen prevention and treatment of drug dependence and HIV infection

UN agencies, other international organizations and donors should assist countries in strengthening interventions to prevent and treat both drug dependence and HIV infection, in building more effective systems for monitoring and evaluation of these interventions and in improving the education of various professionals. In some cases, this will require or benefit from reforms to laws, bylaws, policies, ministerial regulations, guidelines, protocols and operational plans, and based on this review, there is a role for UN technical agencies to assist in areas such as the following:

- drug control and criminal justice policies, and respective administrative and criminal justice legislation (UNODC, OHCHR);
- public health legislation (WHO, UNODC, UNICEF, UNFPA, OHCHR);
- social security/protection legislation (WHO, UNICEF, OHCHR);
- Family Codes (UNICEF,UNFPA, OHCHR);
- Labour Codes (ILO, OHCHR); and
- legislation regulating access to information and education (UNESCO, OHCHR).

Recommendation 60: Support inclusion and participation of vulnerable groups

UN agencies, international organizations and donors should firmly support the inclusion and participation of vulnerable groups in decision-making process and the development of national strategies and laws on HIV and on drugs, including by supporting the legal formalization of this requirement. This will ensure that rights of vulnerable population are not violated or ignored, that law and policy take account of their needs and, therefore, make for a more effective response to these public health problems.

II. COUNTRY REPORTS

AZERBAIJAN

SUMMARY REPORT AND RECOMMENDATIONS

AZERBAIJAN: SUMMARY REPORT AND RECOMMENDATIONS

1. BACKGROUND

In the Republic of Azerbaijan, with a population of approximately 8.5 million, official data as of 2007 suggests some 21,180 people inject illegal drugs (1.8% of them women).[537] As of 2005, 18,259 people were in prison (1.4 % of them women).[538]

According to UNAIDS, in 2007 there was an estimated 7800 people living with HIV in Azerbaijan.[539] Most were in the capital city of Baku, accounting for roughly 66 % of all people diagnosed with HIV. According to UNESCO, approximately 43% of people living with HIV in Azerbaijan are migrants.[540] As of 1 July 2007, the National AIDS Centre had a record of 168 women living with HIV.[541] In 2007, according to the National AIDS Centre, 60 people were receiving anti-retroviral (ARV) treatment (including three women), of which two-thirds were people who use drugs. ARV treatment is available in prisons.

The single most significant driver of the HIV epidemic in Azerbaijan is injection drug use: as of 2007, 57.7% of all cases of HIV infection were among people who use drugs, and the prevalence of HIV among people who inject drugs was approximately 5%. In 2007, the documented prevalence of HIV among prisoners was 2.3%: according to the National AIDS Centre, of 5663 prisoners tested for HIV (which testing is compulsory for prisoners), 132 were HIV-positive. It is also worth noting that, as of 2007, 72% of all people living with HIV in Azerbaijan had been imprisoned at some time.[542]

According to the information provided by the national expert group, there are national and city-based narcological clinics, seven district narcological clinics, and 79 narcological offices under the central and regional hospitals. Only five of them have medical doctors specializing in narcology; in the others, narcological treatment is performed by doctors of other specialties. The national expert group reports that there are no waiting lists for treatment of drug dependence.

The national expert group also reports that, in recent years, on average only about 200 people per year voluntarily have sought treatment for drug dependence from official "narcological dispensaries".[543] Given that somewhere between 800 and 1200 people are treated annually through such dispensaries,[544] but only a small number of these are cases of voluntary treatment, the overwhelming majority of people undergo drug dependence treatment involuntarily — largely through the actions of law enforcement bodies and in the context of criminal prosecutions for drug offences.

There is one opioid substitution therapy (OST) programme in the country, which has been introduced in narcological institutions on the basis of the *Law on narcological service and control*[545] and the *Law on circulation of narcotic substances, psychotropic drugs and precursors*.[546] The OST programme started in January 2004. By January 2006, there were more than 150 participants. In June 2006 the programme was suspended for a period of three months because of a delay in purchasing methadone. As of the end of 2007, there were about 97 patients, of whom 85% are infected with hepatitis C virus (HCV).

537 Information provided in 2007 by the regional office of the UN Office on Drugs and Crime office based on data of the National Narcological Centre.

538 Data provided by the national expert group of the Republic of Azerbaijan (2007).

539 UNAIDS, *2008 Report on the global AIDS epidemic* (Geneva, 2008), Annex 1.

540 UNESCO, *HIV/AIDS in Azerbaijan: A Socio-cultural approach* (2005).

541 Interview with staff of the Ministry of Health, conducted by the national expert team in 2007.

542 This data is provided by the national expert group from Azerbaijan (2007).

543 In the estimation of the national expert group, resort to unofficial drug dependence treatment (e.g. home-based detoxification, visits to other specialty doctors, etc.) is perhaps 10 times higher than seeking treatment in official facilities. This can be attributed to the adverse consequences, including registration as a drug user and associated infringements of rights, of seeking treatment from such dispensaries.

544 Data provided by the national experts, from official annual reports of the Ministry of Internal Affairs and Ministry of Health (2007).

545 *Law "On narcological service and control"*, No.161-IQ (29 June 2001).

546 *Law "On circulation of narcotic substances, psychotropic drugs and precursors"*, No.959-IIQ (28 June 2005).

2. NATIONAL PROGRAMMES AND STRATEGIES

Programmes on HIV/AIDS

The *National Strategic Plan on Prevention of Spread of AIDS for 2002-2006* was approved by the Cabinet of Ministers in 2002.[547] A detailed list of actions provided by the Strategic Plan contained, among other things, peer and other outreach activities, the introduction of HIV prevention programmes targeting "at risk" groups (e.g., needle and syringe exchange), and the distribution of disinfectants and condoms. The Plan also had a number of provisions for the development of national principles for substitution therapy, with priority given to OST for drug users with HIV. Other activities included work with media in order to decrease stigmatization and discrimination against people living with HIV. The Plan had provisions for HIV prevention for prisoners: the involvement of prisoners in harm reduction activities in prisons, and the assessment of drug dependence in prisons. The overall budget of the strategic plan was approximately US$31 million, around one-third of which sum was earmarked for HIV prevention activities.

However, as the national expert group has observed, the Strategic Plan did not provide for the participation of representatives from non-governmental organizations (NGOs), people who use drugs and people living with HIV in decision-making, or any mechanisms to ensure control over and monitoring of the realization of the proposed actions. The Plan did not mention activities aimed at ensuring the anonymity and confidentiality of HIV testing, nor did it contain human rights provisions.

In 2008 the *National Programmatic Strategy on HIV/AIDS (2009–2013)* was adopted.[548] Harm reduction projects were among the basic activities for HIV prevention included in the strategy.

However, needle and syringe programmes (NSPs) are available in Azerbaijan, funded by the Global Fund to Fight AIDS, Tuberculosis and Malaria and the Open Society Institute. In average, 22% of registered injecting drug users are covered by the services of NSP.[549] No state financing is provided for such programmes. Syringes are freely sold in pharmacies, including at night. There is an agreement between the Ministry of Health and the Global Fund (from June 2005) which outlines implementation of needle exchanges and substitution therapy using methadone. There is also an agreement between the Ministry of Health and the Open Society Institute (from December 2005) on the implementation of harm reduction programmes (including NSPs) to prevent HIV, within the scope of the Global Fund project. Needle and syringe programmes can involve former or current drug users as outreach workers. According to the information collected by the national expert group, there are instructions on the safe disposal of used syringes.

Programme on narcotic drugs

The *Programme on Counteracting Trafficking of Narcotic Substances, Psychotropic Drugs and Precursors and Drug Dependence for 2007-2012*[550] is divided into the following sections:

- organizational actions;
- improvement of legislation and international activities;
- activities aimed at rehabilitation, treatment and medical prevention among people who use drugs; and
- prevention of drug dependence aimed at individuals, groups and population as whole.

The programme includes measures aimed at rehabilitation, treatment and prevention of drug use and dependence. Prevention includes the strengthening of educational, awareness, medical and rehabilitation activities based on international experience. It states that the most advanced methods and modern scientific best practices are to be applied for treatment and rehabilitation of people with drug dependence.

With regard to injection drug use, the programme provides for strengthening joint activities of medical institutions and law enforcement bodies to ensure voluntary treatment, as well as integrating people with drug dependence into a "healthy lifestyle". This envisages the creation in the penitentiary system of a specialized drug dependence treatment facility that would meet international standards, as well as activities aimed at HIV prevention among people who use drugs, the implementation of which will involve the Forum of Non-Governmental Organizations.

The State Commission on Counteracting Drug Dependence and Drug Trafficking is the body responsible for coordinating and supervising the implementation of the programme.[551] The State Commission has the following functions, among others: developing the national programme on counteracting drug dependence and drug trafficking; monitoring the situation with drug dependence, illegal drug use and trafficking in the country; drafting laws and amendments on counteracting drug use and drug trafficking, for presentation to the President; and ensuring Azerbaijan complies with international treaties to which it is a party.

According to the national expert group, the programme has no section on budget or sources of funding. It is expected that funding of the actions should be allocated from the general annual budget assigned to the state bodies. The national expert group has concluded that there is a need to revise the programme based on international standards. In particular, it must:

- be complemented with the WHO-approved programmes of harm reduction activities aimed at HIV prevention among people who inject drugs;
- provide detailed sources of funding/budget;
- define indicators to assess its effectiveness; and
- specify organizations responsible for implementation and mechanisms for monitoring.

547 Cabinet of Ministers, "On the approval of the *National Strategic Plan for Prevention of AIDS for 2002–2006*", Resolution No.205s (25 September 2002). The first *National Program on Prevention of AIDS in the territory of the Azerbaijan Republic* was adopted by the Cabinet of Ministers in 1997 for a period of three years.

548 Decree of the Ministry of Health of Azerbaijan "*National programmatic Strategy on HIV/AIDS (2009-2013)*" No.164, (27 July 2008).

549 Information provided by the UNODC country coordinator.

550 *Program on Counteracting Trafficking of Narcotic Substances, Psychotropic Drugs and Precursors and Drug Dependence in 2007-2012,* [Программа борьбы с незаконным оборотом наркотических средств, психотропных веществ и их прекурсоров, а также распространением наркомании на период 2007-2012], Decree of the President of the Republic of Azerbaijan, No. 2271 (28 June 2007). This is the third national program on narcotics after the 1997-2000 and 2000-2006 programs.

551 Statute of the State Commission on Counteracting Drug Dependence and Drug Trafficking, established by Decree of the President of Azerbaijan (27 January 2007).

3. ADMINISTRATIVE AND CRIMINAL LAW PROVISIONS ON NARCOTIC DRUGS

The main governmental bodies responsible for counteracting drug trafficking are the State Commission on Counteracting Drug Dependence and Drug Trafficking (which is not a law enforcement body and has no investigative apparatus) and the main Drug Control Department within the Ministry of the Interior (which conducts investigation of drug-related offences). According to the national expert group, currently there is a trend to toughen Azerbaijan's law enforcement response to drug use and drug trafficking. However, the national expert group's review and assessment has led it to recommend, in the interests of better protecting both public health (including against HIV) and human rights, a number of important changes to the current law and policy in Azerbaijan that would lessen the emphasis on law enforcement and instead emphasize treating drug use and dependence as health concerns.

Administrative offences

Non-medical use of drugs currently leads to administrative liability.[552] The *Code on Administrative Offences* provides liability for manufacturing, cultivating, acquiring, possessing, and sending of narcotic drugs, psychotropic substances and precursors for personal use (as opposed to for sale).[553],[554] Possession of even very small quantities of drugs leads to administrative liability, punishable by a fine or administrative detention for 15 days. Amounts of drugs considered to be "for personal use" are determined by the Cabinet of Ministers (e.g., under 0.15g in the case of heroin).[555] Avoiding drug testing also leads to administrative penalty (fine), which could be ordered by police or other administrative official.[556]

Criminal offences

Depending on the character and degree of the public danger of the offence, criminal offences are divided into offences "of minor public danger", "less serious" crimes, "serious" crimes and "especially serious" crimes.[557] Crimes connected with illegal trafficking of narcotics can be less serious, serious or especially serious. In the majority of cases related to drugs, confiscation of property (acquired by illegal means) is applied after conviction as part of the penalty. Taking into account the character of the offender and the nature and public danger posed by the offence, and other aggravating and mitigating circumstances, the court may decide on a conditional sentence instead of more serious restrictions of freedom or full imprisonment.[558] According to the national expert group, in the majority of drug-related offences, for the stated purpose of ensuring a comprehensive and objective investigation, pre-trial detention is imposed on a suspect to prevent possible attempts to interfere with the investigation.

Azerbaijan's legislation contains a concept of quantity of drugs "for personal use" The criminal law of Azerbaijan distinguishes possession of narcotics for personal use and possession for purposes of sale (see appendix). Additionally:

- According to the *Criminal Code*, illegal acquisition or possession of narcotics or psychotropic substances, *without the intention to sell*, in a quantity which exceeds a defined quantity "for personal use" is a criminal offence punishable by up to three years' imprisonment (i.e. possessing between 0.15g, the ceiling of the "personal use" range, and 0.2g of heroin attracts criminal liability, even if there is no intent to sell).[559]

- Illegal acquisition or possession, *with intention to sell*, of a quantity of narcotics or psychotropic substances exceeding the quantity defined "for personal use" is punishable by three to seven years' imprisonment, with or without the confiscation of property.[560]

In 2007 the Criminal Code was amended by Article 317-2, which criminalises manufacturing, possession, transportation or use of prohibited items by people in pre-trial detention and by prisoners. The List of prohibited items, among other things includes narcotic drugs and psychotropic substances and precursors. The expert group expressed concern that use of drugs in any form, including for medical purposes, may become reason of new criminal charges, which could be applied to preparations used for opioid substitution therapy.

However, as the national expert group has pointed out, detention and imprisonment for drug use and for people who use drugs is not desirable from a public health perspective, including for efforts to prevent HIV transmission among people who use drugs and in prisons. The experts recommended that the government and legislators should, in the case of at least some non-violent drug-related crimes (including drug offences involving small quantities and offences without an intention to sell), introduce alternatives to criminal prosecution and conviction (e.g., treatment for drug dependence where clinically indicated). Furthermore, to the extent that criminal liability remains, the government and legislators should introduce alternatives to imprisonment as a penalty (e.g., fines, community labour, less stringent restrictions on freedom than imprisonment).

The *Criminal Code* provides criminal liability for "incitement to use" narcotics drugs or psychotropic substances, as well as "organizing or running drug consumption sites", each of which is punishable by imposing "limitations of freedoms" for up to three years or imprisonment for two to five years.[561] The *Criminal Code* does not define "incitement", but the *Law on circulation of narcotics, psychotropic substances and precursors* states that it means "direct or indirect incitement to illegal use of narcotics and psychotropic substances by means of artistic, audio, video and other materials, including computerized information and other means."[562] It is important to ensure that such a provision not be interpreted too widely, such that it undermines initiatives by harm reduction programmes to make sure people understand risks associated with drug use (particularly by injection) and that, if they are going to use drugs, they know how to use them in less risky ways.

Free legal aid is provided if the accused: demands a defender; cannot independently represent himself or herself as a minor or because of a disability; does not speak the language in which hearings are conducted; is accused of committing an "especially serious" crime; or is compulsorily placed in a special medical institution.[563] In addition, indigent people who require legal aid in court can receive it at state expense.[564] Thus, the legislation provides guarantees to those accused of committing drug-related crimes and persons who can be placed in a compulsory treatment institution.

Needle and syringe programmes

Possession of drug paraphernalia (syringes, disinfectants, utensils etc.) is not itself a criminal or administrative offence in Azerbaijan.-

There are no provisions in law either obliging or barring police from patrolling pharmacies and needle and syringe programmes. The national expert group has recommended that the new draft *Law on HIV prevention* should have special provisions to ensure that police do not interfere with the work of pharmacies and needle and syringe programmes. In addition, as the national expert group has stressed in its analysis, one of the important conditions for successful and effective implementation of needle and

552 *Code of Azerbaijan on Administrative Offences* [Кодекс Азербайджанской Республики об административных проступках], No. 906-IГ (11 July 2000), Article 68-1.

553 *Code of Azerbaijan on Administrative Offences* [Кодекс Азербайджанской Республики об административных проступках], No. 906-IГ (11 July 2000), Articles 68-2, 68-3.

554 *Code of Azerbaijan on Administrative Offences*, Article 15. Administrative liability begins at the age of 16. In the case of administrative offences committed by persons between the ages of 16 and 18, the Commission on Minors, taking into account the person's specific circumstances, maturity, living conditions, health conditions and level of education, can release the person from administrative liability and resort to other measures.

555 Resolution of the Cabinet of Ministers of Azerbaijan, 12 October 2000. See appendix for a table of how quantities of various drugs are defined for legal purposes under Azeri law.

556 *Code of Azerbaijan on Administrative Offences* [Кодекс Азербайджанской Республики об административных проступках], No. 906-IГ (11 July 2000), Articles 68-1.

557 *Criminal Code of Azerbaijan*, Law No. 787-IГ (20 December 1999), Article 15. Special courts hear cases on "serious" and "especially serious" crimes connected with drugs, while "less serious" cases are heard by district courts. Criminal responsibility for crimes related to stealing drugs or extortion of drugs starts with the age of 14; for other crimes connected with drugs, the criminal liability starts from 16: *Criminal Code*, Article 20.

558 *Criminal Code*, Article 70.

559 *Criminal Code*, Article 234.1.

560 *Criminal Code*, Article 234.2.

561 *Criminal Code*, Articles 236 and 238.

562 *Law On circulation of narcotics, psychotropic substances and precursors*, Article 1.0.16.

563 *Criminal Code*, Article 51.

564 *Law On legal defenders and their activity* [Об адвокатуре и адвокатской деятельности] (28 December 1999), Article 20.

syringe programmes is to ensure confidentiality for clients, which requires approaches such as coding the names of programme clients.

According to the analysis presented by the national expert group, drug dependence represents not only — and not primarily — a law enforcement issue, but rather a public health problem. Thus, in addressing drug use the emphasis should be on health care services to people who use drugs, rather than prosecution, so as to support people in seeking drug dependence treatment and/or reducing or eliminating HIV risk behaviours. Substitution treatment and reducing risks while injecting drugs (including of HIV and other blood-borne infections) are key measures, and the national expert group recommends their widespread implementation in legislation and practice.

Compulsory drug testing by law enforcement

According to the *Law on circulation of narcotics, psychotropic substances and precursors*, drug testing is done to determine drug use, to detect if a person is under the influence of drugs, and to detect concealment in the human body of narcotics and psychotropic substances.[565] Pursuant to a decision by the Cabinet of Ministers of Azerbaijan, if there is a "substantiated suspicion" [обоснованные подозрения] that a person is intoxicated by a narcotic, is driving under the influence of drugs, or carries narcotics and psychotropic substances in his or her body, or if narcotics and psychotropic substances have been found on a person, he or she may be subjected to medical examination at the request of police.[566] The medical examination is conducted in state narcotic medical institutions. If the person refuses to be tested, an administrative fine may be imposed.[567]

Other vulnerable groups: criminal and administrative law issues

Sex work:

In Azerbaijan, prostitution is an administrative offence and leads to fine (35-50 amounts of minimal monthly wage), according to Article 308 of the *Code of Administrative Offences*.

The *International Guidelines on HIV/AIDS and Human Rights* recommend that "with regard to adult sex work that involves no victimization, criminal law should be reviewed with the aim of decriminalising and legally regulating occupational health and safety conditions to protect sex workers and their clients, including support for safe sex during sex work".[568] Criminalizing sex work and sex workers contributes to their further stigmatization and marginalization, putting them at greater risk of human rights abuses and exacerbating vulnerability to HIV. It is recommended to decriminalise sex work, in compliance with international standards.

HIV and STI exposure and transmission:

Articles 139 and 140 of the Criminal Code of Azerbaijan provides for criminal liability for

- Transmission of venereal diseases by a person who knew of his/her infection is punishable by fine (300-500 minimal monthly wage) or correctional works for up to two years, or imprisonment for up to two years. The same offence committed in relation of two or more people or to a minor, is punishable by imprisonment for up to four years.[569]
- Knowingly exposing someone to HIV infection, is punishable by correctional works for up to two years, limitation of freedom for up to two year, or imprisonment for up to one year.
- HIV transmission by someone who knew of his/her HIV infection, is punishable by imprisonment from two to five years. HIV transmission by someone who knew of his/her HIV infection, to two or more people or a minor, is punishable by imprisonment from five to eight years.
- HIV transmission due to negligent performance of ones professional duties, is punishable by imprisonment for up to three years, and prohibition to hold certain positions for up to three years.[570]

565 *Law on circulation of narcotics, psychotropic substances and precursors*, Law No.959-IIQ (28 June 2005), [Закон Об обороте наркотических средств, психотропных веществ и прекурсоров], Article 25.

566 Cabinet of Ministers, Resolution No.135 (7 August 2000).

567 Cabinet of Ministers, Resolution No. 135 (7 August 2000).

568 *International Guidelines on HIV/AIDS and Human Rights*, Guideline 4, para. 21(c).

569 *Criminal Code of Azerbaijan*, Article 139.

570 Ibid., Article 140.

Having a specific criminal offence singling out HIV exposure and negligent HIV and STI transmission, runs contrary to internationally recommended policy, in part because it stigmatizes people living with HIV, and people vulnerable to it, and creates a further disincentive for HIV and STI testing and an additional barrier to access to health services. The *International Guidelines on HIV/AIDS and Human Rights* recommend against such an approach: criminal legislation should not include specific offences regarding HIV transmission or exposure, and the scope of applying criminal law should be limited to those cases where someone acts with malicious intent to transmit HIV and does in fact transmit the virus.[571]

571 Joint United Nations Programme on HIV/AIDS & Office of the High Commissioner for Human Rights, *International Guidelines on HIV/AIDS and Human Rights,* Guideline 4, para. 21(a); UNAIDS, *Policy Brief: Criminalization of HIV Transmission* (2008).

4. PROVISION OF HEALTH CARE SERVICES

The *Constitution of the Republic of Azerbaijan*[572] and regulatory acts[573] guarantee free treatment unlimited in time, including free treatment of "socially significant diseases", such as HIV/AIDS, narcological diseases, tuberculosis and hepatitis.[574] The *Law on public health care*[575] also refers to "socially dangerous diseases" [общественно опасные заболевания], the list of which includes mental illnesses, drug dependence, alcoholism, HIV/AIDS, leprosy, syphilis and tuberculosis.[576]

To use public health services, one needs to produce an identification card. Medical services cannot be denied to patients who are unemployed or homeless. According to the national expert group's assessment, often such categories of people are "long-term" patients of narcological institutions. According to instructions of the Ministry of Health, treatment of concurrent HIV, drug dependence, tuberculosis, or hepatitis C could be simultaneous and parallel.[577] There are no restrictions in obtaining public health care for migrants and refugees.[578] According to the national expert group, drug use cannot be the reason for denial of treatment, including treatment of hepatitis or tuberculosis, or provision of ARV treatment. However, drug use in infectious and tuberculosis hospitals can be considered a violation of internal rules, and can lead to discharge from hospital (but it cannot justify termination of out-patient treatment).

Theoretically, if a health care professional refuses to render medical help without "sufficient reasons" [уважительных причин], when he or she is obliged to provide service in accordance with the law or rules, if it leads to an injury to health, this is punishable by a fine, community labour or a term of imprisonment.[579] Under the legislation on HIV/AIDS, a refusal by public health workers to provide medical assistance leads to administrative liability, however, no cases have been initiated to date.[580]

Despite the fact that regulatory documents provide for a low threshold of access to public health services, the national expert group has noted that the reality is often different. A primary reason is the lack of funding to provide services. According to the national expert group, even if there are no delays in hospitalization, patients often need to provide for their own food, medicines and bed linen. Sanitary and hygienic conditions in medical institutions are sub-optimal. The national expert group has reported that the government recognizes the problem, and is allocating funds from the budget to the public health care services; there are also institutional reforms underway. In addition, according to the national expert group, changes need to be made in the professional training system, as currently there are almost no experts in fields such as psychological assistance, social support or harm reduction.

According to the national expert team, there is a need to develop high quality monitoring tools to assess health care services and the implementation of the existing legislation. The *Law on public health care* needs to be amended to include provisions obliging corresponding executive authorities to develop modern mechanisms of statistical reporting and mechanisms for quantitative and qualitative standards of health care services, and to introduce modern standards in the curricula of medical institutions.

The *Law on prevention of physical disability, rehabilitation and social protection of the disabled* provides that a person is "disabled" under that law if he or she "…is a person with limited ability to perform vital functions, and needing social assistance and protection due to congenital or acquired disease or trauma or intellectual or physical defects".[581] The restriction of the ability to perform vital functions can be expressed in a full or partial loss of mobility, of behavioural control, of orientation, or of the ability to care for oneself, to communicate or to work. HIV and drug dependence are classified as diseases; based on their condition and according to the assessment procedure established by the legislation, persons with HIV or drug dependence may fall under the definition of "disabled" and therefore be entitled to social assistance.

572 *Constitution of Azerbaijan* (12 November 1995).

573 E.g., see *Law on prevention of HIV and AIDS* [О предотвращении распространения ВИЧ и СПИДа], Law No. 282-IQD (25 April 1997), Articles 3 and 4.

574 The legislation defines the maximum term of sick leave as four months. For a longer period, an examination determining "disability" is necessary.

575 *Law on public health care* [Закон об охране здоровья населения], Law No. 360-IQ (26 June 1997).

576 The list of diseases is set out in a decision adopted by the Cabinet of Ministers, Resolution No.5 (12 January 1990).

577 Order No. 112 (8 November 2001), Appendix No.3.

578 *Law on prevention of HIV and AIDS*, Article 4.

579 *Criminal Code*, Article 142.

580 *Law on prevention of HIV and AIDS*, Article 10. According to the national expert group's report, the President of the PLWHIV Association in Azerbaijan advised the group that no cases of denial of treatment had been recorded.

581 *Law on prevention of physical disability, rehabilitation and social protection of the disabled* (25 August 1998).

4A. DRUG DEPENDENCE PREVENTION AND TREATMENT

The state guarantees free treatment for drug dependence; however, as the national expert group has noted, often patients or their relatives must purchase medicines and food out of pocket.
As noted above, according to the *Law on narcological service and control*, drug dependence is defined as a "chronic disease", and could be considered a disability, which leads to payment of social benefits.[582] This provision makes the legislation of Azerbaijan different from many other countries and allows potential protection of the rights of people dependent on drugs, in particular protection from discrimination. However, until now neither the Cabinet of Ministers, nor the Ministry of Social Protection have developed required regulatory legal acts to address mechanisms of providing social assistance for those with drug dependence.

The provision of health care services to persons with drug dependence is regulated by the *Law on narcological service and control*, decisions of the Cabinet of Ministers and regulations of the Ministry of Health. There are no separate regulatory documents defining the standards for treatment of drug dependence. Drug dependence treatment is provided in narcological institutions operated by public bodies. The creation of private narcological institutions is limited by the *Law on private medical practice*, which excludes the treatment of "socially dangerous diseases" from the list of services that may be rendered by private health care institutions.[583] Private health care institutions cannot provide OST.

Currently in Azerbaijan, drug dependence treatment is limited to detoxification treatment and one OST programme providing treatment to 97 persons. According to the national expert group, programmes of medical or social rehabilitation, psychological support, 12-step programmes and psychotherapy do not exist. According to the national experts, the number of beds for female patients in narcological institutions is limited, numbering approximately 40 as of their report (in 2007). Women represent approximately 10% of registered drug users. The national expert group's assessment is that conditions in narcological institutions do not meet the necessary sanitary and hygienic requirements. They have noted as well that children are not allowed to stay with their mothers during treatment. The national experts recommended that harm reduction programmes in the country should contain information on HIV and drug use prevention, intended specifically for women.

Opioid Substitution Treatment

The *Law on narcological service and control* does not define substitution treatment, but the list of narcological services provided by the state includes substitution therapy.[584] Programmes of opioid substitution treatment (OST) are regulated by the *Law on circulation of narcotic substances, psychotropic drugs and precur*sors,[585] while procedures are laid out in a Resolution of the Cabinet of Ministers.[586] There are plans for two more pilot projects in cities of Sumgait and Lenkoran, but at the beginning of 2009 these project have not started yet.

In order to be eligible for OST in Azerbaijan, patients must (1) have been using opioids for at least two years; (2) have unsuccessfully attempted detoxification twice; and (3) be at least 18 years old. Priority is given to pregnant women, people with HIV and AIDS, patients with hepatitis B or C, patients with oncological and other serious physical diseases and patients with septic conditions. There are no restrictions on the time of treatment: long-term maintenance is possible, as are treatment programmes aimed at

582 *Law on narcological service and control*, Article 16.5.

583 *Law on private medical practice* [О частной медицинской деятельности], Law No. 789-IГ (30 December 1999).

584 *Law on narcological service and contro*l, Article 9 (1.4) includes substitution treatment as form of drug dependence treatment.

585 *Law on circulation of narcotic substances, psychotropic drugs and precursors*, Article 11.

586 Cabinet of Ministers Resolution "*Terms and procedures of substitution therapy in health care programs for people who use drugs*", [Условия и порядок проведения заместительной терапии в лечебных программах лиц, потребляющих наркотические средства] No. 021 (26 January 2006).

eventual abstinence but using methadone on a short-term (one month), medium-term (up to 3 months) or longer-term (6 months) basis. The choice of treatment strategy depends on the patient. The terms are defined only on the basis of consultations with the patient and his or her intentions.

The regulatory documents provide for a possibility of the patient to participate in discussion of the treatment, choice of the dose and, based on medical indications, the possibility for prescribing take-home doses of medication.[587] Dismissal from the programme is possible for serious misconduct, such as abuse of programme staff. Patients receiving OST may be punished for illegal drug use, which punishment may include: a restriction on the time when the medicine is given, more frequent conversations with the psychologist, short-term suspension from the programme, and finally, a discharge, without right to return. According to the national expert group, such measures of punishment were applied very rarely. In AIDS centres, tuberculosis hospitals, etc, drug use is prohibited by internal regulations, and on this basis, the patient can be dismissed from the hospital (but out-patient treatment can be continued). Illicit drug use should not *per se* be a reason to discharge someone from an OST programme or reduce dosages as punishment, although it may raise clinical issues about how to manage OST.[588] Nor is it an acceptable basis for denying other health care services.[589]

Drug user registration

Registration of people who use and who are dependent on drugs is regulated by decisions of the Cabinet of Ministers.[590] Registration is based upon diagnosis of drug dependence (or behavioural disorder caused by drug use), according to the World Health Organization's definition.[591] People are registered as drug dependent if they seek voluntary treatment or following compulsory drug testing imposed by police or courts. According to the national expert group, data on registered people is kept by narcological institutions and is confidential; police (under the jurisdiction of the Ministry of the Interior) receive only the numbers of people registered. (As noted below, however, police may also demand confidential health information of patients, and the law requires that it be provided in the event of such a demand.)

Compulsory drug dependence treatment

National legislation provides for compulsory treatment of drug dependence in two cases:

- First, compulsory treatment may be ordered by a court if a person is found guilty of a crime and requires treatment for drug dependence (or alcoholism).[592] Compulsory treatment in this case is ordered by court during sentencing, to be imposed in addition to any penal sentence, rather than as an alternative to imprisonment. Treatment is conducted in a specialized medical institution in prison on in-patient or out-patient basis.

- Second, if a person's actions inflicted moral or pecuniary damage on family members or negatively influenced a child's education, or if the person has repeatedly evaded "voluntary" drug dependence treatment, the person may be referred to treatment following a court decision, based on an application brought by a family member.[593] According to the national expert group, this provision has not yet been applied in practice.

587 The national expert group reports that there have been two cases in which "take-away" doses have been prescribed over the three years of the program's existence, but the dose was delivered by a nurse to another wing of the hospital or another hospital. These were not instances in which the patient is prescribed several days' doses of methadone which he or she takes away for personal administration outside the health care setting.

588 E.g., S. Maxwell and M. Shinderman, "Optimizing response to methadone maintenance treatment: use of higher-dose methadone," *Journal of psychoactive drugs* 31 (1999): 95–102.

589 WHO/UNODC, *Principles of Drug Dependence Treatment: Discussion Paper* (March 2008), p. 10.

590 Cabinet of Ministers, "Rules and procedure for establishment of special supervision over persons to whom narcological assistance is provided", Decision No.131 (12 August 2002) and "Order and rules for establishing a record on dispensary supervision of narcological patients", Decision No.136 (19 August 2002). [Правила и порядок установления специального наблюдения над лицами, которым оказывается наркологическая помощь; Порядок и правила взятия на учет и диспансерного наблюдения наркологических больных].

591 Cabinet of Ministers "Order on establishment or recognition of the narcological diagnosis during examination of a person suffering from drug dependence", Decision No. 186 (26 November 2002) [Порядок проведения медицинского обследования на предмет установления или подтверждения наркологического заболевания]. This Decision adopts the WHO's approach to characterizing drug dependence: see International Statistical Classification of Diseases and Related Health Problems, 10th Revision ["ICD-10"], and specifically the diagnostic guidelines for drug dependence at www.who.int/substance_abuse/terminology/definition1/en/.

592 *Criminal Code of Azerbaijan*, Article 93.1.4.

593 *Law of Azerbaijan on trafficking of narcotic substances, psychotropic drugs and precursors*, Article 27.3; and Cabinet of Ministers Resolution "Terms and procedures of compulsory treatment for people who use drugs in specialized health care facilities" [Условия и порядок прохождения принудительного лечения для потребителей наркотиков в специализированном медицинском учреждении], No. 020, 26 January 2006.

The national expert group has also reported that, as a general rule, compulsory treatment of drug dependence is not applied to minors.

Overdose prevention

Naloxone, an opioid antagonist medication used to counter the effects of opioid overdose (including suppression of the central nervous and respiratory systems), is listed by the WHO as an essential medication for treating poisonings.[594] Naloxone is not considered to be a prohibited substance under Azerbaijani law, but as a rule it is not procured by the government. The medicine is delivered to the country by private entities. Use of naloxone in cases of overdose is not regulated by regulatory or legal documents. According to the information provided by the national experts of Azerbaijan, in cases of overdoses where a patient arrives in narcological or emergency care, medical personnel are obliged to report such cases to law enforcement bodies.

Need for education and training

The national expert group has underlined that there is a need to organize education and training for medium-level officials who make political and organizational decisions. These persons collect information in the field, analyse the situation, prepare recommendations and draft decisions for the top management. In addition, there is a need to extend types of health care and social services for people who use drugs. In this regard, modifications need to be made into training programmes, with the introduction of new training courses and programmes. The absence of training, including advanced training courses, limits what health care professionals are qualified to provide by way of care. The national expert group has observed that treatment of drug dependence is largely limited to detoxification.

The national expert group has also expressed concern about the poor system of medical and social services, and the scarcity and underdevelopment of such services; in its view, this contributes to negative public opinion about dealing with the health aspects of drug use, allowing law enforcement bodies to strengthen their role in dealing with problems of drug use. Furthermore, the main goal behind many activities aimed at preventing drug dependence is to present a negative image of people who use drugs, contributing to further stigmatization and discrimination against them. A continuing expansion of preventive programmes for various population groups is required. This requires policies and programmes that are based on treating drug use, and drug dependence, primarily as health concerns rather than law enforcement concerns — and this requires services that treat patients with respect and that are supported by qualified health professionals.

4B. HIV PREVENTION AND TREATMENT

The *Law on prevention of HIV and AIDS* was adopted in 1997.[595] The law has no provisions on HIV prevention among "at-risk groups", such as people who use drugs, sex workers and men who have sex with men (MSM). Nor does it have provisions on blood safety measures, the rights of people living with HIV/AIDS or the provision of ARV treatment. However, the law is progressive in a number of other respects, such as the absence of compulsory HIV testing of foreign citizens and the deportation of HIV-positive foreigners. According to the national expert group, the 1997 law has become outdated; it recommends developing a new draft *Law on prevention of HIV and AIDS*.

This law does guarantee full and free health care services for people living with HIV and AIDS. The out-patient network for palliative care to patients with AIDS is practically non-existent, although such programmes are supposed to be organized as part of the project of the Global Fund to Fight Tuberculosis, AIDS and Malaria. HIV infection is defined as a "third category" physical disability, while AIDS is recognized as a "second category" or "first category" disability (higher degree of severity, which is determined by a spectrum of conditions). As noted above, this means that persons with HIV may be entitled to social assistance.

Unfortunately, according to the information provided by the national expert group, HIV prevention among

594 WHO, WHO Model List of Essential Medicines, regularly updated, online: http://www.who.int/medicines/publications/essentialmedicines.

595 *Law on prevention of HIV and AIDS*, Law No. 282-IQD (25 April 1997).

people who use drugs, and the provision of medical services to this group of patients, are very limited and of poor quality. There is little interest on the part of specialized medical bodies (e.g., those dealing with tuberculosis or dermatological, venereal, or narcological diseases) to implement HIV prevention measures including pre- and post-test counselling.

According to the national expert group, currently no HIV education is required as part of the school curriculum, although information on HIV may be given in optional classes. According to the analysis conducted by the experts, ensuring that youth receive adequate information about HIV and other STIs should be a key priority as part of a comprehensive HIV prevention effort.

In 2005, the Ministry of Health approved the "National Protocol for HIV/AIDS Prevention and Assistance to People living with HIV and AIDS" [Национальный протокол профилактики ВИЧ/СПИДа, и ведения ВИЧ инфицированных и СПИД больных]. This document was prepared with technical assistance from WHO experts and was a major step forward. The protocol contains HIV prevention measures, including activities aimed at vulnerable groups. Educational programmes, both for the population as a whole and targeting specific vulnerable groups, are included. Criteria for providing ARV treatment, protocols for the treatment of co-infections, and voluntary counseling and HIV testing were also mentioned. However, this document lacks any substantive provisions on human rights protection or mechanisms for the participation of civil society in decision-making. According to the national experts, a new version of this document has been adopted.

HIV testing

Currently, the *Law on prevention of HIV and AIDS* mentions the possibility of anonymous HIV testing.[596] According to national experts, anonymous HIV testing is performed on a fee-for-service basis; the fee is paid to the AIDS centre. In such cases, no counselling is provided. Anonymous testing is, therefore, only to those who can pay privately.

Pre- and post-test counselling can be done both by state and non-governmental organizations, including by medical workers, organizations providing harm reduction services, outreach workers and peer educators. However, HIV testing is done in the laboratory of AIDS Centre, and in the regions the first level of tests is conducted in the laboratories of the Centre of Hygiene and Epidemiology, and in the laboratories of the blood transfusion and hematology institute.[597] Upon an initial positive test, blood samples are sent to the AIDS centre for repeat testing. After confirmation of the diagnosis, AIDS Centre staff set up an appointment with the person at the Centre or visit the person in the medical institutions where they are treated.

The *Law on prevention of HIV and AIDS* has a general guarantee that HIV testing should be done only with informed consent.[598] The *Law* itself requires compulsory HIV testing only for blood donors.[599] However, subsequent orders from the Ministry of Health have subsequently expanded considerably — and largely without adequate justification — the list of those who are subject to involuntary HIV testing, without informed consent, such that it now includes the following long list of people:

- sex workers;
- men who have sex with men;
- pregnant women;[600]
- people who use drugs;
- prisoners;
- persons with sexually transmitted infections (STIs), tuberculosis or hepatitis;
- workers of food sector and pre-school centres.[601]

On the positive side, foreign citizens are not subject to compulsory testing.

596 *Law on prevention of HIV and AIDS*, Article 8.

597 Ministry of Health, Order No.157 (23 October 1997), Appendix, Article 1(1)

598 *Law on prevention of HIV and AIDS*, Articles 6-9.

599 *Law on prevention of HIV and AIDS*, Article 7.

600 Pre- and post-test counselling is provided to pregnant women (although testing is required and can be done without consent).

601 Ministry of Health, Order No.157 (23 October 1997), Appendix, Article 1(2).

According to international standards, an HIV test should be done on a voluntary basis only, except for obligatory tests for donors of blood and organs.[602] If HIV testing is ever to be imposed without consent, then it requires a process clearly set out in law, with a requirement that such measures be taken only in exceptional circumstances and with adequate justification that must be considered by an independent, judicial body, and with the most limited infringement of human rights possible.[603] In preparing a new draft law on HIV/AIDS, the national expert group has emphasized the need to pay particular attention to the principle of voluntary testing. HIV testing should be done in accordance with international standards, including human rights norms. The national experts underlined that informed consent is a pre-condition to any medical intervention. Compulsory testing undermines such human rights as security of the person, privacy and confidentiality.

Patients' rights, including confidentiality

The rights of patients are provided in the *Law on public health care*, according to which patients have rights to the following:

- to give a voluntary written or oral consent to medical intervention;
- refuse treatment;
- the confidentiality of information on their treatment, state of health, diagnosis, and any other data received during examination and treatment; and
- to decide for themselves to whom such information can be made available.[604]

In the event of a breach of these rights, patients can seek a remedy from the management of the health institution in question or the courts.[605]

The *Code on Administrative Offences* prohibits someone from "avoiding treatment" if he or she has been advised of infection with HIV or another STI by public health care institutions; avoiding treatment is punishable by a fine.[606] Similarly, it is an administrative offence, again punishable by fine, for a person to avoid HIV or STI testing after being notified by public health officials that he or she has been identified as a contact of someone diagnosed with HIV or another STI.[607] It is an administrative offence, punishable by fine, for a person who is diagnosed with HIV or another STI to conceal past contacts and, if known, the identity of the source of his or her infection.[608]

Confidentiality of health information

Confidentiality of HIV testing and counselling is ensured by a number of regulatory legal acts. For example, the *Law on prevention of HIV and AIDS* makes public health authorities and other persons legally liable for breaching confidentiality of patients by impermissibly disclosing information on HIV status.[609] The *Law on public health care* creates the requirement of "medical secrecy" but also provides an exhaustive list of situations in which disclosure of medical secrets without consent of the patient is possible.[610] According to this article, the fact of seeking health care assistance, and a patient's diagnosis, health situation, or other data received during examination and treatment, represent medical secrets which should be kept confidential. With the consent of a patient (or his or her legal representative) consent, medical information could be passed on to others: in the interests of examination or treatment, for use in scientific research, publications in scientific literature, educational and other purposes.

Information can be disclosed without a patient's consent in the following situations:

602 UNAIDS/WHO Policy Statement on HIV Testing (June 2004).

603 Guidelines such as the UN's *Siracusa Principles* on permissible limitations on human rights should be complied with in any legislative provision that would allow involuntary testing or treatment: UN Economic and Social Council, *Siracusa Principles on the Limitation and Derogation Provisions in the International Covenant on Civil and Political Rights*, UN Doc. E/CN.4/1985/4, Annex (1985).

604 *Law on public health care*, Law No. M360-IQ (26 June 1992), Article 24.

605 *Ibid.*

606 *Code on Administrative Offences*, Article 61.

607 *Ibid.*, Article 62.

608 *Ibid.*, Article 63.

609 *Law on prevention of HIV and AIDS*, Article 18.

610 *Law on public health care*, Article 53.

- for the purpose of examination and treatment, if a person is not able to describe his or her condition;
- if there is a risk of spread of infectious diseases, mass poisoning or injuries;
- if there is request from police, public prosecutor and court;
- for the purpose of informing parents or representatives of minors; or
- if there is a suspicion of illegal activities and/or harming others.[611]

Confidentiality of the information in electronic and paper databases recording people living with HIV is provided by coding of patient information, with the internal system of coding known only to the employees of the AIDS Centre. There is no uniform system of coding in the country. No instructions exist to govern use of the data. However, according to the national expert group's report, in practice, disclosure of medical secrets concerning people living with HIV/AIDS is common. Medical information about people with HIV is most often provided to heads of medical institutions, to heads of penitentiary institutions, and upon demand by law enforcement bodies.

There is a national information bank on drugs, psychotropic substances and precursors, drug-related activities and persons who use drugs, established by a Resolution of the Cabinet of Ministers.[612] Access to information is restricted; valid grounds must be presented to gain access to the data. The Cabinet resolution lists the agencies authorized to request this information as follows: the Ministries of Health, Internal Affairs, Justice, Economic Development, and National Security; the Office of the Public Prosecutor; the Border Control Service; the Customs Committee; and other corresponding bodies.[613] Access to the information on people who use drugs is only possible if person charged with administrative or criminal offence.

611 *Law on public health care*, Article 53.

612 Cabinet of Ministers, "Order of submission and access to data contained in the national information databank on imports, exports and transit of narcotic substances, psychotropic drugs and precursors, and the persons participating in illegal circulation of narcotic substances and psychotropic drugs or consuming drugs" [Порядок отправления и получения сведений в общенациональный информационный банк данных об импорте, экспорте и транзите наркотических веществ, психотропных средств и их прекурсоров, а также лицах, участвующих в незаконном обороте наркотических веществ и психотропных средств или потребляющих наркотики], Resolution No.181 (6 October 2005).

613 *Ibid*., para. 5.

5. PRISONS

Azerbaijan's correctional system

Penitentiary institutions in Azerbaijan are within the purview of the Ministry of Justice. According to the *Penal Code* they can be of the following types: correctional colonies for adolescents; colonies for adults (of various security levels); prisons (cell-based blocks as opposed to settlement-type colonies); and medical institutions for prisoners.[614] Penitentiary institutions can be of general, strict, and special security regime. There are 51 penitentiary institutions in Azerbaijan, including three pre-trial detention facilities. Colonies (correctional settlement of various types of security) are subdivided into colonies of the general and maximum security regime. There are no specialized bodies for prevention and treatment of HIV/AIDS in the penitentiary system: HIV-positive prisoners are contained in same facilities with the rest of inmates, whereas persons with tuberculosis are kept separately.

As of 2007, over 2000 people classified as drug dependent were in penitentiary institutions in Azerbaijan, 950 of them undergoing treatment for drug dependence. According to the statistics provided by the national expert group, over 7000 prisoners received treatment for drug dependence in prisons between 1989 and 2007.[615] According to the national expert group, prisoners with HIV and AIDS are provided with ARV treatment.

The legislation allows for involvement of non-governmental organizations in public control over the penitentiary institutions. NGOs can participate in the rehabilitation and education of prisoners; while NGOs have access to prisons, their work is to be restricted to preventive (educational) work with prisoners, including providing HIV education and information.[616]

Health care in prisons

Health care services in penitentiary institutions are provided by the Medical Department of the Ministry of Justice. According to the national expert group, health care services in prisons are not adequate, but if needed prisoners have a right to receive paid health care services. There is a department for treatment of persons with drug dependence. There are no provisions that committing an offence under influence of drugs is an aggravating circumstance, which is a welcome feature of Azeri law.[617]

HIV testing, prevention and treatment in prisons

Voluntary HIV testing and treatment is conducted on the basis of the *Penal Code*[618] and Prison Regulations. According to the national expert group's report, neither the *Penal Code* nor Prison Regulations envisage compulsory HIV testing for prisoners or prison staff. Details for the voluntary testing are specified in the Order of the Ministry of Health.[619]

Although Azerbaijani law includes harm reduction provisions, there is no mention in the law of harm reduction activities in prisons. According to the information presented by the experts, HIV prevention activities in prisons consist of providing information about HIV. According to the legislation, HIV prevention and educational activities in prisons could be carried out by NGOs, who also have right to conduct civic control over penal institutions.[620] In order to obtain permission to carry out educational and preventative activities in a penitentiary, an NGO needs to apply to the Public Committee on Civil Control over the Penitentiary System [Общественный комитет, осуществляющий контроль над исполнением наказаний в пенитенциарных учреждениях], which consists of the Ministry of Justice officials and representatives of NGOs.

Tuberculosis is a major concern in prison settings, particularly for prisoners with HIV or otherwise-com-

614 *Penal Code of Azerbaijan* [Кодекс исполнения наказаний] (14 July 2000), Article 66.

615 Data provided by the expert group.

616 *Penal Code of Azerbaijan*, Article 20.

617 *Criminal Code*, Articles 59 and 61.

618 *Penal Code of Azerbaijan* [Кодекс исполнения наказаний], Law No. 908- IГ (14 July 2000), Article 93.2.

619 Ministry of Health of Azerbaijan, Order No. 157, (23.10.1997).

620 *Penal Code,* Article 20.

promised immune systems. Tuberculosis prevention and control measures include: sanitary and administrative supervision in the penitentiary institutions by way of active prevention, early diagnosis and effective treatment; timely referral of the patients to anti-tubercular medical institutions; timely detection of the persons who had contacts with tuberculosis patients, and their examination, preventive treatment, and regular check-up; isolation of persons with active tuberculosis; and regular medical checkups, diagnostics and treatment.

Health care services for people with infectious diseases, including HIV, are provided in medical-sanitary departments of the penitentiary via out-patient and in-patient treatment facilities. Disabled prisoners, prisoners with infectious diseases and prisoners receiving in-patient treatment in health care departments of the penitentiary are permitted to purchase a double amount of food and other necessary products.[621] Disabled prisoners, pregnant women and prisoners with serious diseases are not limited in the number of parcels they can receive from outside of prisons.[622]

Prisoners with HIV are not provided with special work conditions; their labour is carried out on the regular basis. There no provisions protecting prisoners from sexual and other forms of violence; sexual violence in prisons is regulated by general provisions of criminal law.

Drug dependence treatment

There is no regulation specifically on voluntary drug dependence treatment in prisons and it is not carried out.

There is a special chapter on compulsory drug dependence treatment in the *Penal Code*.[623] Compulsory treatment is ordered in addition to a penal sentence, on the basis of narcological expertise, the term of treatment is defined by a judge, and does not constitute an alternative to criminal punishment. The *Penal Code* also provides that if drug dependence is discovered during imprisonment, the penitentiary institution may seek a court order imposing compulsory treatment.[624] Thus, it appears that all drug dependence treatment in prisons is carried out on a compulsory basis. Internal regulations provide for a possibility of compulsory drug testing of prisoners. As the national expert group has noted, there is no mention in law of harm reduction activities with regard to drug use in penitentiary institutions.

As a general rule, prisoners with a record of good behaviour at some point in the sentence can be transferred for serving the rest of the sentence to an institution with lesser security (i.e., colony- settlement). However prisoners ordered to undergo compulsory drug dependence treatment cannot be transferred to institutions with lesser security.[625]

Release from prison

The *Criminal Code* does allow for compassionate release based on health status.[626] According to an order of the Minister of Justice, persons with AIDS at a terminal stage of illness may be exempted from serving a sentence of imprisonment.[627] There is a special *Law on social rehabilitation of persons released from prisons*, which regulates housing, public health care and other aspects of life of people upon release from prison.[628]

621 *Penal Code,* Article 80.4.

622 *Penal Code,* Article 82.2.

623 *Penal Code,* Article 91.7.

624 *Penal Code of Azerbaijan*, Article 17.3.

625 *Ibid*., Article 70.3.3.

626 *Criminal Code*, Article 78; *Criminal Procedure Code*, Article 511.

627 Minister of Justice, Order No. 3T (2003).

628 *Law on social rehabilitation of persons released from prisons,* [Закон о социальной реабилитации лиц, освобожденных из пенитенциарных учреждений] (31 May 2007).

6. ANTI-DISCRIMINATION PROVISIONS

The *Constitution of the Republic of Azerbaijan* guarantees to everybody equality of rights and freedoms irrespective of race, nationality, religion, language, sex, descent, property and official status, beliefs, political creed, association with trade unions and other public organization. Limitation of human rights and freedoms on the above grounds is prohibited.[629] Everyone has the right to public health care and health services.[630] Everyone has a right to privacy and family life.[631] The *Criminal Code* prohibits "violation of equality" but does not define "discrimination" as such.[632]

Azerbaijani law prohibits limitations on the rights of people living with HIV/ AIDS and members of their families. The *Law on prevention of HIV and AIDS* prohibits "dismissal from job, refusal to employ or enroll to pre-school or educational institutions, or provide health care service, and restriction of other rights and interests of people living with HIV and members of their families, based on the disease".[633] The *Law on prevention of physical disability, rehabilitation and social protection of disabled* is devoted to protection of rights, freedoms and legitimate interests of persons with disabilities and prohibits any discrimination based on disability.[634]

Despite this, HIV-positive status and drug use and dependence are treated elsewhere in the law as the basis for discriminatory restriction of number of rights.

Discrimination in employment

Theoretically, the law prohibits any discrimination in employment based on factors which are not connected with personal competence, professional skills, or performance of the worker; this includes granting direct or indirect advantages and privileges on the basis of such factors.[635] However, as noted above, drug testing may be mandatory as a pre-condition of employment. The potential employer is obliged to inform the applicant of the requirements of the job, including an obligatory drug test.[636] After informing a job applicant about mandatory drug testing as a condition of employment, and after the applicant consents, the employer issues a referral, valid for three days, to a state narcological institution. Results of drug testing are kept in the private personnel file of the employee. The employer also has the right to repeat drug testing, but not more than once a year. The Cabinet of Ministers has defined a list of 18 trades and professions which people who use drugs are precluded from holding.[637] This restriction may be lifted after 5 years of "remission" from drug use.[638]

Parental rights

The *Family Code* provides that chronic drug or alcohol dependence can be the basis for deprivation of parental rights in cases of concern about child neglect or abuse.[639] Other grounds for deprivation of parental rights are: "negative influence on a child", failure to perform parental duties, abuse of parental rights, physical mistreatment of children and abuse, and crime against children, spouse or others. The procedure for depriving someone of parental rights can be initiated by an application from relatives or child protection bodies. Under the current law, the health condition of alcoholism or drug dependence is

629 *Constitution of Azerbaijan*, Article 25.

630 *Constitution of Azerbaijan*, Article 41.

631 *Constitution of Azerbaijan*, Article 32.

632 *Criminal Code of Azerbaijan*, Article 154.

633 *Law on prevention of HIV and AIDS*, Article 10.

634 *Law on prevention of physical disability, rehabilitation and social protection of the disabled*, Article 8.

635 *Labour Code of Azerbaijan* (1 February 1999), Article 16. Furthermore, the law states that granting advantages and benefits specifically to women, people with disabilities, persons under 18 and other persons requiring social protection is not considered to be discriminatory.

636 *Law on narcological service and control*, Article 24(3); *Law on circulation of narcotic substances, psychotropic drugs and precursors*; Cabinet of Ministers, Decision No. 145 (12 September 2002) and Decision No. 18 (8 February 2003).

637 Cabinet of Ministers, Decision No. 18 (8 February 2003). This list includes: drivers of public and all other types of transport, law enforcement and rescue services, staff of pre-school institutions, people whose work is connected with large sums of money or involves drugs; paramedics and emergency doctors, health care staff working with analgesics, oncologists, and other health cares staff who can prescribe narcotic drugs; people responsible for safety at work, professions working with firearms, security; professions in the oil and gas sector, or positions involving working with high voltage equipment or an increased risk of fire or explosion.

638 *Law on narcological service and control*, Article 24.3; *Law on circulation of narcotic substances, psychotropic drugs and precursors*; Cabinet of Ministers, Decision No.145 (12 September 2002) and Decision No. 18 (8 February 2003).

639 *Family Code of Azerbaijan* (28 December 1999), Article 64.

an aggravating factor that may be the basis for depriving parents of their children. Such categorization of people with drug dependence is of concern, given the risk that drug or alcohol dependence will be assumed to be *per se* sufficient to deprive parents of their custody or other rights vis-à-vis their children: denying parental rights should require case-by-case justifications, based on an assessment of individual circumstances, rather than based on inaccurate, generalized assumptions about a person's capacity to be a suitable parent based on health status.

Spousal relations: If during entering marriage a spouse conceals infection with HIV or another STI, the other spouse may seek to have the marriage nullified.[640] As a general rule, spouses and former spouses are obliged to support each other if one of them becomes unable to support himself or herself.[641] However, this responsibility may be lifted by court decision if a person became unable to work as a result of alcoholism, drug use or committing an offence.[642]

The national expert group concluded that stigmatization, social prejudices and discrimination against people living with HIV and their partners, friends and family, is one of the main obstacles in effective HIV prevention and treatment. Stigma can be manifested in different ways, including: alienation and avoidance of people living with HIV; discrimination against people with HIV by their families, health care professionals, communities and the government; the requirement of obligatory HIV testing or performing testing without informed consent; breaches of confidentiality motivated by fear of HIV; violence against people who are considered to be HIV-positive or belong to 'risk groups'. It is obvious that the stigma connected with HIV aggravates problems and stress for the people living with HIV, and complicates HIV prevention and treatment. The national expert group has recommended action be taken to counteract such stigmatization and discrimination. Addressing some of the unjustifiable discrimination in legislation and official policy would be an important element of that effort.

640 *Ibid.*, Article 13.3.

641 *Ibid.*, Articles 84-86.

642 *Ibid.*, Article 87.0.1.

7. CONCLUSIONS AND RECOMMENDATIONS

The recommendations below are aimed at addressing issues identified by the national expert group of Azerbaijan and by the project's technical advisors. Suggested language of legislative amendments is highlighted.[643]

National programmes and strategies

Recommendation 1: Key elements of a new national plan on HIV/AIDS

The national expert group has recommended that any new national plan on HIV/AIDS needs to:

- include activities on HIV prevention for people who use drugs and prisoners, including harm reduction services;
- include activities aimed at improving the level of health care services and facilitate access to HIV/AIDS care and treatment for people who use drugs and prisoners;
- provide detailed implementation mechanisms and financing sources;
- define progress and target indicators, responsible organizations, monitoring mechanisms, and timeframes; and
- ensure participation in decision-making of NGOs, people living with HIV and people who use drugs.

Recommendation 2: Implement a sound national programme on drugs

The national expert group has recommended that the current national programme on drugs needs to be revised, in line with international standards and best practices. In particular, the national programme should:

- include evidence-based, WHO-supported harm reduction interventions aimed at preventing HIV and other harms among people who use drugs and among prisoners;
- include measures to scale up access to evidence-based treatment for drug dependence that respects clinical and human rights standards;
- be accompanied by a detailed budget, with confirmed funding allocated by the government;
- define indicators to assess its effectiveness;
- specify the organizations responsible for implementation and mechanisms for monitoring implementation; and
- ensure participation in programme development and implementation by NGOs and, to the extent feasible, people who use drugs.

Recommendation 3: Establish clear responsibility for HIV prevention efforts within government

To coordinate HIV prevention work effectively, the government should clearly identify the legal responsibility for HIV prevention of a government body, which would include representatives of legislative and executive branches of government, NGOs, media, and other stakeholders to develop and approve a state strategy to respond to HIV/AIDS.

643 In many instances, the wording of proposed legislative amendments is adapted from model provisions in Legislating for Health and Human Rights: Model Law on Drug Use and HIV/AIDS (Toronto: Canadian HIV/AIDS Legal Network, 2006), online in both English (www.aidslaw.ca/modellaw) and Russian (www.aidslaw.ca/modellaw-ru). This publication, consisting of a series of 8 modules on different issues, was used as a key reference by UNODC, national expert groups and the project's technical advisors during the review and assessment of national legislation in the countries participating in the project. Where relevant, citations below are to specific modules of that resource; the accompanying text and commentary to be found in those modules may be useful to legislators and policy-makers in implementing these recommendations.

Administrative and criminal law issues

Recommendation 4: Decriminalize and depenalize possession of drugs for personal use

Currently, possession of a prohibited drug in a small quantity "for personal use" (e.g. under 0.15g of heroin) is not a criminal offence, which is a welcome feature of Azerbaijaii law. However, possessing even such a small amount remains an administrative offence punishable with a fine or administrative detention for 15 days. Furthermore, possession of what is defined as a "large" quantity (e.g., 2g of heroin), even if it is only for personal use, remains a criminal offence and can be punished with up to 3 years in prison. Given the nature of drug dependence as a chronic, relapsing condition, such provisions criminalize and penalize people with drug dependence. The Government of Azerbaijan should consider entirely removing penalties, whether administrative or criminal, for possession of drugs for personal use. This could be achieved, in part, by enacting a provision such as the following in either the *Code of Administrative Offences* or the *Criminal Code* (or both):[644]

> The possession of a controlled substance for personal use shall attract neither criminal nor administrative liability.

If it were thought necessary to maintain a definition of what constitutes an amount for "personal use" that a person is allowed to possess without criminal or administrative liability, then it is recommended that the quantities currently set out in the law be revisited, with a view to raising these quantities so as to reduce the resort to criminal or administrative penalties for people with drug dependence.

Additionally, the expert group notes, that it is recommended to amend Article 317-2 of the Criminal Code (the Article provides for criminal liability for manufacturing, possession, transportation and use of prohibited items, which include narcotic drugs and psychotropic substances, by prisoners and persons in pretrial detention). The Article should be amended by a note, specifying that possession and consumption of narcotic drugs for medical purposes and following physician's prescription exclude criminal liability. It will also be necessary to introduce similar amendments to the *Penal Code* and the *Internal Regulations of penitentiary institutions*.

Recommendation 5: Depenalize drug use and other administrative offences related to small quantities of drugs for personal use

Currently, it is an administrative offence to use drugs or engage in a variety of activities involving small "for personal use" quantities of prohibited drugs, such as acquiring, sending, manufacturing, etc., which *de facto* penalize the personal use of controlled substances. The national expert group recommends depenalizing the personal use of controlled substances. To this end, Articles 68-1, 68-2, and 68-3 of the *Code of Administrative Offences of the Republic of Azerbaijan* should be repealed.

Recommendation 6: Compulsory drug testing

According to Article 25 of the *Law on circulation of narcotics, psychotropic substances and precursors*, any person "for whom there are proven suspicions that s/he is intoxicated by narcotics or carries narcotics or psychotropic substances in the body, and the person on whom narcotics and psychotropic substances are found, can be subjected to medical examination pursuant to the legislation".[645],[646] The *Code of Administrative Offences* also imposes administrative liability for avoiding drug testing.[647] As outlined above, such provisions infringe numerous human rights. Among other things, compulsory drug testing violates privacy and security of the person, without justification in most circumstances, since merely showing past use of drugs does not prove there is a risk of harm to self or others, which should be the only basis for possibly justifying an intrusion by the state into such rights. This provision also contradicts other provisions of

644 See *Legislating for Health and Human Rights: Model Law on Drug Use and HIV/AIDS*, Module 1: Criminal law issues, pp. 18-21.

645 *Law on circulation of narcotics, psychotropic substances and precursors*, Article 25.

646 Cabinet of Ministers, Resolution No.135 (7 August 2000).

647 *Code of Administrative Offences,* Article 68-1.

Azeri law. It is, therefore, recommended that both Article 25 of the *Law on circulation of narcotics, psychotropic substances and precursors* and Article 68-1 of the *Code of Administrative Offences* be repealed.

Recommendation 7: Create clear legislative framework for needle and syringe programmes

With the objective of supporting effective HIV prevention among injection drug users and protecting the public health more generally, the national expert group has recommended creating a clear legislative framework for needle and syringe programmes, including the disposal of used syringes. Wording of legislative provisions such as the following could be introduced to the existing *Law on prevention of HIV and AIDS* or other suitable legislation:[648]

> **Sterile syringe programmes**
>
> 1. "Sterile syringe programme" means a programme that provides access to sterile syringes and other related material, information on HIV transmission and other blood-borne pathogens, or referrals to substance abuse treatment services. It includes needle exchange programmes, needle distribution programmes and other forms of sterile syringe distribution.
>
> 2. Staff of the sterile syringe programme may provide a range of material and services, including the following:
> a) sterile syringes and other related material for safer injection drug use, including sterile water ampoules, swabs, filters, safe acid preparations, spoons and bowls and other appropriate materials;
> b) material to enable safer smoking and inhalation of drugs, such as pipes, stems, metal screens, alcohol wipes and lip balm;
> c) condoms and other safer sex materials, such as water-based lubricants and dental dams, as well as information about reducing the risks of HIV and other sexually transmitted infections; and
> d) first aid in emergency situations.
>
> 3. Staff of sterile syringe programmes may provide information including, but not limited to, the following:
> a) drug dependence treatment services and other health services;
> b) means of protection against transmissible diseases, including blood-borne diseases such as HIV;
> c) the risks associated with the use of controlled substances;
> d) harm reduction information specific to the drug being used, including safe injecting and inhaling practices;
> e) legal aid services;
> f) employment and vocational training services and centres; and
> g) available support services for people with drug dependence and their families.
>
> 4. The state shall ensure access to sterile syringes for people who require them. Where sterile syringes are not otherwise available and there is demand, the state shall establish a sterile syringe programme out of public funds. The state may distribute sterile syringes through public health facilities or provide funding to community organizations to operate sterile syringe programmes.

Recommendation 8: Avoid criminal and administrative liability for harm reduction programmes

The harm reduction and outreach activities of non-governmental organizations, such as programmes providing sterile syringes or other equipment to reduce harms associated with drug use (including HIV transmission), should be clearly exempt from possible liability. In particular, they should be exempt from liability under Article 234 (trafficking of drugs in small quantities) or Article 236 of the *Criminal Code* (incitement to drug use), as well as Article 1.0.16 of the *Law on circulation of narcotics, psychotropic substanc-*

648 See *Legislating for Health and Human Rights: Model Law on Drug Use and HIV/AIDS*, Module 3: Sterile syringe programs, pp. 12-13.

es and precursors (direct or indirect incitement to illegal use of narcotics or psychotropic substances).[649] Specific legislative provisions such as the following could achieve this, inserted into the *Criminal Code*:[650]

> **Exemption from liability for sterile syringes and other harm reduction programmes**
>
> Nothing in this *Criminal Code* or any other law prevents the supply of syringes and other related material, or the giving of advice, information or instruction on the safe use of syringes and other related material, by staff of a sterile syringe programme or other programme aimed at reducing harms associated with the use of prohibited narcotics or psychotropic substances, and nothing in the *Criminal Code* or any other law gives rise to any liability for such activities.

Recommendation 9: Ensure policing does not undermine harm reduction

Police actions in enforcing laws against narcotics and psychotropic substances can, while legally authorized, be done in ways that directly undermine the effectiveness of measures aimed at protecting the health of drug users and the broader public, including by reducing the spread of HIV. It is recommended that national legislation or another appropriate legal instrument (e.g., a decision or regulation) explicitly recognize this, and provide a clear directive to law enforcement bodies that they avoid patrolling near drugstores and sterile syringe programmes or other similar harm reduction services. The national expert group has recommended that the new *Law on HIV prevention* include a provision to address this concern. In addition, or alternatively, such a provision could be added to the *Law on circulation of narcotics, psychotropic substances and precursors*. Such a provision (or provisions) could be worded as follows:

> **Policing practices that do not interfere with harm reduction services**
>
> 1. In the interests of ensuring effective operation of harm reduction programmes and similar services aimed at preventing HIV transmission and other harms among those who use narcotics or psychotropic substances, law enforcement bodies shall refrain from patrolling in the vicinity of such programmes and services for the purpose of targeted enforcement of laws on narcotics or psychotropic substances.
>
> 2. The presence of a person on the premises, or observation of a person entering or exiting the premises, of such a programme or service does not, in itself, constitute sufficient grounds to detain, search, arrest, charge or convict a person in relation to any offence related to a narcotic or psychotropic substance.

Alternatively, the legislation (or other instrument) could establish a mechanism for outlining such directives or guidance to law enforcement bodies, through a provision such as the following:

> The Ministry of Health shall be responsible for convening a working group to establish a protocol for law enforcement practices in the vicinity of sterile syringe and other harm reduction programmes, with the goal of ensuring their effective operation.

Recommendation 10: Decriminalise sex work

It is recommended to repeal Article 308 of the *Code of Administrative Offences* (sex work). The *International Guidelines on HIV/AIDS and Human Rights* recommend that with regard to adult sex work that involves no victimization, criminal law should be reviewed with the aim of decriminalising and legally regulating occupational health and safety conditions to protect sex workers and their clients, including support for safe sex during sex work.[651] The criminal prohibition on recruiting people for sexual or other exploitation and other existing criminal law provisions to deal with assault, coercion and human trafficking are sufficient for addressing human rights abuses which require attention.

649 *Law on circulation of narcotics, psychotropic substances and precursors*, Article 1.0.16, which defines "incitement' as direct or indirect incitement to illegal use of narcotics and psychotropic substances by means of artistic, audio, video and other materials, including computerized information and other means.

650 See *Legislating for Health and Human Rights: Model Law on Drug Use and HIV/AIDS*, Module 3: Sterile syringe programs, pp. 19-21.

651 *International Guidelines on HIV/AIDS and Human Rights* (Guideline 4, para. 21(c)).

Recommendation 11: Eliminate HIV and STI-specific criminal law

Articles 139 and 140 of the *Criminal Code*, which specifically provide for punishment for transmission and exposure to "venereal diseases" and HIV, should be repealed. In the case of intentional transmission of venereal or HIV infection, this could be dealt with as infliction of bodily harm that is covered by other articles of the *Criminal Code*.

Drug dependence treatment

Recommendation 12: Scale up access to opioid substitution treatment

The national expert group has recommended widespread implementation not only of sterile syringe programmes but also greater access to opioid substitution treatment (OST) as a key measure for HIV prevention among people who inject drugs. While existing legislation already provides for implementing and regulating OST programmes,[652] it seems that action has not yet taken place to make such programmes a reality beyond pilot projects. The clear recommendation is to expand such programmes without further delay.

Recommendation 13: Ensure OST programmes comply with good practices

Currently, in the limited OST programmes that exist, there is a system of punishment for illegal consumption of drugs, such as punitive (as opposed to clinical) reductions in OST dosage, restriction of timing for delivery of the preparation, more frequent visits to the psychologist, short-term removal from the programme, or, finally, prohibition to return to it. Given the nature of drug dependence as a chronic, relapsing condition, punitive approaches to providing OST are unethical and do not comply with good practice; clinical decisions (e.g., about dosage, conditions of participation, withdrawing OST from a patient) should be made based on advancing the best interests of the patient. Either the Cabinet decision or Ministry of Health order governing OST should include provisions such as the following:[653]

> **Duration of treatment and dosage**
>
> 1. The prescribing physician shall determined the appropriate dose of the prescribed opioid substitute in consultation with the patient and in accordance with best medical practice. The dosage shall aim to achieve an effective level of physical and psychological discomfort while minimizing the likelihood of overdose.
>
> 2. The dosage should not be held out as a reward to the patient, nor withheld as a punishment of the patient.
>
> 3. The duration of treatment should be adequate to ensure the treatment's effectiveness according to best medical practice.
>
> **Eligibility for take-away doses**
>
> 1. The determination of eligibility for take-away doses of a prescribed opioid substitution treatment shall be based solely on:
>
> a) the clinical stability of the patient; and
>
> b) the patient's ability to comply with the procedures of the programme.
>
> 2. The prescribing physician shall have discretion to initiate take-away doses for patients who do not meet the eligibility criteria in Section 1 where:
>
> a) the patient has a medical condition or disability that limits his or her mobility; or

652 *Law on narcological service and control*, Article 9 (1.4) includes substitution treatment as form of drug dependence treatment; *Law on circulation of narcotic substances, psychotropic drugs and precursors*, Article 11; Cabinet of Ministers, Decision No. 21 (26 January 2006).

653 See *Legislating for Health and Human Rights: Model Law on Drug Use and HIV/AIDS*, Module 2: Treatment for Drug Dependence, pp. 26-28.

b) the distance the patient must travel to the clinic or other health care setting, or other circumstance, restricts the patient's ability to have his or her consumption supervised on each occasion.

3. The prescribing physician shall specify the procedures for take-away doses in writing and shall ensure that copies are provided to the patient and the dispensing pharmacist.

Withdrawal from substitution treatment

1. A patient shall have the right to voluntarily withdrawn from treatment at any time.

2. The prescribing physician or another qualified health professional shall fully inform the patient of the potential risks and benefits of withdrawal from treatment and shall work with the patient to ensure the patient's safety and comfort during the withdrawal process.

3. The prescribing physician shall not discontinue services that are needed unless the patient requests the discontinuation, alternative services are arranged or the patient is given a reasonable opportunity to arrange alternative services.

4. The withdrawal from treatment with an explanation of likely consequences shall be recorded or registered in medical documentation and signed by the patient and health practitioner.

5. Involuntary withdrawal from treatment shall be avoided except where compelling reasons exist. Regulations governing grounds for involuntary withdrawal shall be clearly communicated to patients at the outset of treatment.

Recommendation 14: Provide rehabilitation after drug dependence treatment

It is recommended to introduce in the *Law on narcological service and control* the concept of rehabilitation, to expand the kinds of the narcological assistance provided by the state and by NGOs.

Recommendation 15: Repeal provisions on drug user registration

According to current law of Azerbaijan, people are registered as drug dependent if they undergo drug dependence treatment (including voluntary treatment) or following compulsory drug testing imposed by police or courts. The national expert group and the project technical advisors observe that the current system of registration of drug users is one factor that discourages people from seeking medical treatment, including for drug dependence, and provides a basis for various infringements of confidentiality. It is therefore recommended that the government begin an assessment of the efficacy and cost-effectiveness of the current approach. This should be included in a consultation process about reforming Azerbaijan's drug policy and practices with a view to reforming the system to ensure it is effective in protecting and promoting health and in respecting and protecting human rights. In doing so, it is necessary to review the Resolutions of the Cabinet of Ministers on registration of people who use and who are dependent on drugs.[654]

Recommendation 16: Protect human rights of people with drug dependence in treatment

In order to better respect and protect human rights, including to confidentiality, and to remove barriers to people voluntarily seeking treatment for drug dependence, the national expert group has recommended a number of amendments to the "*Law on circulation of narcotics, psychotropic substances and precursors*" as follows:

- Article 7.1.6 (regarding procedure for registration): delete the words "and the persons suffering from

654 «*Rules and procedure for establishment of special supervision over persons to whom narcological assistance is provided*»; No.131, (12 August 2002); and «*Order and rules for establishing a record on dispensary supervision of narcological patients*» No.136, (19 August 2002). [Правила и порядок установления специального наблюдения над лицами, которым оказывается наркологическая помощь; Порядок и правила взятия на учет и диспансерного наблюдения наркологических больных].

drug dependence", in order to distinguish between people who use drugs and are dependent on drugs from people engaged in trafficking. According to the expert group, this amendment would also lead to decrease in violations of labour and housing rights of people who use drugs.
- Exclude from Articles 8.2.3 and 8.3 (sections on national databank at the Ministry of Internal Affairs) provision on registering people who use drugs. This amendment will lead to decrease in violation of human rights of people who use drugs. According to the analysis of the expert group, the above provision makes people reluctant to seek drug dependence treatment in government facilities, and makes them to look for unprofessional help.
- Article 10.1 (regarding provision of health cares services in state owned facilities): replace the words "only in state" with the words "regardless of ownership". This amendment will widen the scope of medical assistance provided in private health facilities.

Recommendation 17: Various amendments to the *Law on narcological service and control*

The national expert group further recommended the following steps to bring the *Law on narcological service and control* in line with modern standards of drug dependence treatment:

- Article 1 (definitions): Add a definition of opioid substitution treatment, such as the following: "Opioid substitution treatment means the administration of an opioid substitute to a person with dependence on a pharmacologically related opioid, for achieving defined treatment aims, including maintenance treatment".

- Article 5 (general principles of provision of narcological assistance and supervision): Guarantee scientifically-proven epidemiological studies and regional and local sociological surveys to ensure adequate range of services and the drug situation.

- Article 9: (a) Add a provision on HIV/AIDS preventive programmes among injection drug users, with the use of programmes of exchange and distribution of syringes, outreach, educational programmes, on pre-test and post-test counselling, etc.; (b) Require scientifically proven epidemiological researches and regional, local sociological surveys be organized once every three years, for the purpose of assessing the prevalence and consumption of the psychoactive substances, addictive behaviour and preparation of a country report on drugs.

- Repeal Articles 9.3, 11.6, 12.2, 13, 14.3, 18.0.1, 18.0.2, and 19, which regulate procedures for registration and supervision over narcological patients and the prohibition of drug dependence treatment by non-state narcological institutions.

- Article 11.5 (on treatment by other methods): Delete the words "only in state health care facilities" so as treatment can be performed in both private and public facilities.

- Article 16 (social measures in the field of narcological assistance): Include provisions aimed at introducing measures for HIV prevention in the penitentiary system. (See recommendations regarding prisons below for some specific details of what such measures should entail.)

Recommendation 18: Confidentiality of drug dependence treatment

The following wording is recommended for inclusion in both the *Law on narcological service and control*:

(1) The confidentiality of all health care information shall be respected. Records of the identity, diagnosis, prognosis or treatment of any patient which are created or obtained in the course of drug dependence treatment:
a) are confidential;
b) are not open to public inspection or disclosure;
c) shall not be shared with other individuals or agencies without the consent of the person to whom

the record relates; and
d) shall not be discoverable or admissible during legal proceedings.

(2) No record referred to in Section (1) may be used to
a) initiate or substantiate any criminal charges against a patient; or
b) act as grounds for conducting any investigation of a patient.

(3) Programme staff cannot be compelled under any other law to provide evidence concerning the information that was entrusted to them or became known to them in this capacity.

(4) All use of personal information of patients and programme staff in research and evaluation shall be undertaken in conditions guaranteeing anonymity, and any such information shall also be governed by Section (2) of this article.

Recommendation 19: Compulsory drug dependence treatment as alternative to criminal penalty

The national expert group has recommended differentiating between compulsory treatment for persons with mental disorders and for people with drug dependence. The expert group recommends that treatment of drug dependence should, as a general rule, be voluntary, but that in the event a person who is drug-dependent is convicted of possession of narcotics or psychotropic substances, without an intention to sell, non-voluntary drug dependence treatment should be an *alternative* to imprisonment, rather than in *addition* to imprisonment. (Consideration should be given to expanding this to include not just the offence of possession without intention to sell, but other non-violated offences related to drugs for personal use. In addition, some assessment of drug dependence should form part of this approach to sentencing, to avoid sentencing people to treatment that they do not need.) To this end, amendments should be made to the provisions on compulsory treatment in both the *Criminal Code* (Article 93) and the *Law on narcological service and control* (Article 26), as follows.

Alternatives to prosecution and imprisonment for certain drugs offences

Option 1: Referral to quasi-judicial commission

(1) The sections below apply to the following offences involving a narcotic or psychotropic substance when those offences are committed in circumstances that do not involve violence and there is no accusation of an intention on the part of the accused person to sell said substance: i.e. under Articles 68 of the *Code on Administrative Offences* and Article 234.1 of the *Criminal Code*:

Non-medical use of drugs; manufacturing, cultivating, acquiring, possessing, and sending of narcotic drugs, psychotropic substances and precursors for personal use (as opposed to for sale)

Illegal acquisition or possession of narcotics or psychotropic substances, *without the intention to sell*, in a quantity which exceeds a defined quantity "for personal use"
(2) The offences referred to in section (1) shall be processed, and penalties applied if applicable and necessary, by a quasi-judicial commission ("the Commission").

(3) The Commission shall include a legal expert, as well as other experts such as medical practitioners, psychologists, social service workers or others with appropriate expertise in the field of drug dependence.

(4) The rules of procedure governing the proceedings of the Commission, including the admissibility of medical evidence, shall be determined by the Ministry of Justice and the Ministry of Health.

(5) In arriving at the appropriate penalty for a person apprehended by police for the offences referred to in Section (1), the Commission shall consider:
(a) the seriousness of the act;
(b) the relative degree of fault;
(c) the type of substance involved in the offence;
(d) the public or private nature of the offence and, if relevant, the location of the offence;
(e) the personal circumstances, namely economic and financial, of the offender; and
(f) whether the offender is an occasional, habitual or dependent drug user.

(6) The Commission may apply penalties including, but not limited to, one or more of the following:
(a) a notice of caution;
(b) a fine in proportion to the amount of the narcotic or psychotropic substance possessed for personal use, taking into account the economic situation of the alleged offender;
(c) restriction on travel or attendance in certain places;[655] and
(d) suspension of driving or professional licenses.

(7) The penalties applied by the Commission shall not include custodial penalties.

(8) If the person apprehended for the offences referred to in Section (1) is found by the Commission to be dependent on a narcotic or psychotropic substance, the Commission may order that the person attend a specified number of meetings with the provider of a drug dependence treatment programme, the purposes of which shall be to ensure the person is aware of the programme's services that may assist in overcoming drug dependence and to determine whether the person wishes to avail himself or herself of the services of the programme. The Commission may not compel the person to undergo drug dependence treatment.

Option 2: Non-custodial sentencing measures

(1) Notwithstanding the provisions of this or any other statute, where

(a) a person is found guilty in a court of law of the offence of possession of a narcotic or psychotropic substance contrary to the law;
(b) in the court's opinion, taking into account the quantity of the substance possessed and all other relevant circumstances of the case, the use or possession of a narcotic or psychotropic substance was for the purpose of personal use; and
(c) the applicable sentence would ordinarily include a custodial sentence;

a court shall, rather than imposing a custodial sentence, order one or more of the following:
(a) direct that the person be discharged absolutely or on the conditions prescribed in a probation order;
(b) suspend the passing of sentence and direct that the person be released on the conditions prescribed in a probation order;
(c) fine the person, if the court is satisfied that the person is able to pay the fine;
(d) order that the person serve the sentence through community service, subject to the person's complying with the conditions of a conditional sentence order; or
(e) make a supervised attendance order with the consent of the person requiring him or her to attend a place of supervision for such time as is specified in the order and, during that time, to carry out such instructions as may be given to him by the supervising officer within the lawful exercise of that officer's authority.

(2) As a term of a probation order or a conditional sentence order in Section (1), the court may order that the person attend a specified number of meetings with the provider of a drug dependence treatment programme, the purposes of which shall be to ensure the person is aware of the programme's services that may assist in overcoming drug dependence and to determine whether the person wishes to avail himself or herself of the services of the programme. The court may not compel the person to undergo drug dependence treatment.

655 Note that it will be important to avoid an order that prohibits the person from entering an area where important health services (e.g., needle and syringe programs, health clinics, etc.) are located.

(3) The court may make an order as described in Section (1) if the court considers it to be in the best interests of the accused and not contrary to the public interest, having regard to the age and character of the offender, the nature of the offence and the circumstances surrounding its commission. In making such a determination, the court shall consider the results of any clinical assessment that may have been made of the person.

Recommendation 20: Overdose prevention and management

In order to prevent deaths and other serious harms from overdoses among opioid users, outreach workers — including those working for non-governmental organizations and including "peers" who are themselves persons who use or have previously used drugs) — should be given the legal right to distribute and administer medications such as naloxone in cases of overdose. This could be done by introducing provisions such as the following into the *Law narcological service and control*:

Administration of an opioid antagonist

(1) The Ministry of Health must make provision for the appropriate training of outreach workers in the administration of opioid antagonists.

(2) An outreach worker may administer an opioid antagonist to another person if:
a) the worker believes, in good faith, that the other person is experiencing a drug overdose; and
b) the worker acts with reasonable care in administering the drug to the other person.

(3) An outreach worker who administers an opioid antagonist to another person pursuant to Section (1) shall not be subject to civil liability or criminal prosecution as a result of the administration of the opioid antagonist.

Defining outreach work

(1) "Outreach work" means a community-oriented activity undertaken to contact and provide information and services to individuals or groups from particular populations at risk of blood-borne diseases, particularly those who are not effectively contacted or reached by existing information and services or through traditional health care channels.

(2) "Outreach workers" include paid social or public health workers or unpaid volunteers (including peers) of governmental or non-governmental facilities

(3) Outreach workers may include people who currently use drugs, people who formerly used drugs or people who do not use drugs and are trusted by people who use drugs.

In order to preclude overdose complications in prisons, it is recommended to allow peer educators among prisoners and prison staff to administer naloxone in case of overdose in penitentiary institutions, and train them to use this emergency response medication.

HIV prevention and treatment

Recommendation 21: New HIV law
The national expert group recommended that deputies of the Parliament of the Republic of Azerbaijan together with other stakeholders (including NGOs and people living with HIV and people who use drugs) developed the new draft *Law on the prevention of HIV*, which law should:

- include provisions on HIV prevention for vulnerable groups, such as people who use drugs and prisoners;
- narrow the scope of mandatory and obligatory HIV testing;
- provide for voluntary testing with informed consent and pre- and post-test counseling; and
- strengthen provisions on confidentiality.

Recommendation 22: Ensure informed consent to HIV testing

The national expert group has noted the necessity of a clear legal requirement to ensure people give consent to HIV testing that meets the requirements of informed consent, and that testing be accompanied by pre- and post-test counselling.

- While the details could be set out in different instruments (e.g., a regulation or order from the Ministry of Health), it would also be advisable to include, in the *Law on prevention of HIV and AIDS*, a provision along the lines of the following:

No test for HIV or other blood-borne disease shall be undertaken except with the informed voluntary consent of the person being tested, which informed consent should be clearly documented in writing.

- It is recommended to cancel the orders of the Ministry of Health on obligatory HIV tests for pregnant women, people who use drugs, persons with STIs, prisoners and people with tuberculosis.[656]

Recommendation 23: Training of health professionals, monitoring of services

The national expert group recommended adding to the *Law on public health care* provisions obliging the Ministry of Health to develop forms of statistical reporting and mechanisms of quantitative and qualitative assessment of supplied medical services, introduction of modern science and practice developments in curriculums and practice of medical institutions, to carry out monitoring of quality and efficiency of services.

Recommendation 24: Improve system of professional training

The national expert group also recommended changes to the system of professional training and specialists in the field of psychological assistance, social support, harm reduction, in order to pay more attention to human rights standards.

Recommendation 25: Other patient rights

Provisions on the rights of patients should be strengthened — to the benefit of all patients, and not just those with HIV, STIs or drug dependence — by explicitly adding provisions such as the following to a law such as the *Law on public health care*:[657]

Every patient has the right:
a) to treatment and provided in accordance with good clinical practice;
b) to treatment without discrimination;
c) to meaningful participation in determining his or her own treatment goals;
d) to meaningful participation in all treatment decisions, including when and how treatment is initiated and withdrawal from treatment;
e) to exercise his or her rights as a patient;
f) to confidentiality of medical records and clinical test results; and
g) to be fully informed, including but not limited to the right to receive information about:
i) his or her state of health;
ii) his or her rights and obligations as a patient, as specified in any applicable law;
iii) the procedure for making a complaint about health services received; and
iv) cost and payment conditions and the availability of medical insurance and other possible subsidies.
h) to decline treatment and testing

656 Ministry of Health, Order No. 157 (23 October 1997).

657 See *Legislating for Health and Human Rights: Model Law on Drug Use and HIV/AIDS*, Module 2: Treatment for drug dependence, pp. 18-19.

Prisons

Recommendation 26: Voluntary drug dependence treatment in prisons, including OST

Given the high prevalence of drug dependence among those imprisoned, the significance of risky drug use practices in contributing to the HIV epidemic, and the importance of providing access to health services that respect human rights and help promote the highest attainable standard of health for all persons, it is recommended that Azerbaijan implement voluntary drug dependence treatment programmes in prisons. As OST is made available outside prisons, it should similarly be made available inside prisons as one important element of programmes for addressing drug dependence.

To this end, should amendments be introduced to the *Law on narcological service and control*, so as to create a clear legal framework for substitution therapy that protects and promotes the human rights of patients receiving OST, those amendments should include explicit reference to providing access to OST to drug-dependent persons in prisons. Such a provision could be worded as follows (and could also be inserted into legislation such as the *Penal Code*):[658]

Opioid substitution treatment programmes in prison

(1) The Ministry of Health, with the support and cooperation of the Ministry of Justice, shall establish opioid substitution treatment programmes in all prisons.

(2) Prisoners with opioid dependence shall be eligible for opioid substitution treatment in accordance with opioid substitution treatment guidelines applicable in the community.

(3) Opioid substitution treatment shall be available for free on imprisonment and throughout the duration of imprisonment.

(4) Opioid substitution treatment shall not be restricted to those on a course of opioid substitution treatment prior to imprisonment; all prisoners shall be entitled, if eligible, to being on opioid substitution treatment while incarcerated.

(5) Participation in the opioid substitution treatment programmes shall be offered on a voluntary basis to all prisoners with opioid dependence.

(6) Opioid substitution treatment programmes may include a variety of approaches, including maintenance treatment.

(7) The programme shall ensure that staff members, prison officers, policy makers and prisoners have factual information regarding opioid substitution treatment.

(8) The programme shall develop a comprehensive discharge planning system for prisoners nearing release, including a system for referral to opioid substitution treatment programmes in the general community.

Recommendation 27: HIV prevention in prisons and detention facilities

In order to strengthen HIV prevention efforts in prisons and pre-trial detention facilities, legislative amendments could mandate the introduction of harm reduction programmes in prisons. The "Internal Regulations" of penitentiary institutions should be revised to strengthen HIV prevention among prisoners, including by ordering measures to ensure access to bleach and sterile syringes, as well as ensuring access to condoms, and information related to risks of HIV transmission through unsafe sex or drug use. The Internal Regulations' provisions prohibiting prisoners from possessing needles and syringes should be removed. The expert group recommended including in Article 12-1 (the right to medical services) of the *Penal Code* provisions about free access to HIV prevention programmes and harm reduction interventions, access to sterile syringes and injection kits, condoms and other means of safe sex and provide access to information to ensure awareness about correct application of activities for harm reduction, using effective methods of information delivery. This could be achieved with provisions such as the following:[659]

Distribution and possession of condoms and other safer sex materials in prisons

(1) The Ministry of Health and the Ministry of Justice shall ensure that condoms and other safer sex materials, along with appropriate information on their proper use and on their importance in preventing the spread of HIV infection and other sexually transmitted infections, are made available and easily accessible to prisoners in a manner that protects their anonymity.

(2) The Ministry of Health shall develop a plan for the disposal of used condoms that protects the anonymity of prisoners and the health of prison officers.

(3) The distribution and possession of condoms and other safer sex materials in prisons in accordance with this law shall not constitute a criminal nor administrative offence, nor are condoms and other safer sex materials admissible as evidence of sexual relations for the purposes of determining any criminal or administrative offence.

Authorization of harm reduction programmes

(1) Harm reduction programmes shall be implemented in all prisons according to the provisions set out herein, with the objective of reducing harms associated with unsafe use of drugs, including the risk of transmission of HIV or other blood-borne diseases.

(2) In order to prevent the spread of blood-borne diseases and minimize the health risks associated with drug use by prisoners, either the Ministry of Health or a local prison authority may authorize a specified person or organization (including non-governmental organisations) to deliver harm reduction programmes, including measures to supply sterile syringes and other related material to prisoners, as well as condoms and other materials to reduce the risks of HIV and other sexually transmitted infections.

Information

Staff of harm reduction programmes may also provide information including, but not limited to, the following:
(a) drug dependence treatment services and other health services;
(b) means of protection against transmissible diseases, including blood-borne diseases such as HIV;
(c) the risks associated with the use of controlled substances;
(d) harm reduction information specific to the drug being used, including safe injecting and inhaling practices;
(e) legal aid services;
(f) employment and vocational training services and centres; and
(g) available support services for people with drug dependence and their families.

Distribution and possession of sterile syringes and related material

(1) An authorized person or organization may distribute sterile syringes and related material via one or more of the following means:
(a) prison nurses or physicians based in a medical unit or other area(s) of the prison;
(b) prisoners trained as peer outreach workers;
(c) non-governmental organizations or health professionals who enter the prison for this purpose;
(d) one-for-one automated sterile syringe-dispensing machines.

658 See *Legislating for Health and Human Rights: Model Law on Drug Use and HIV/AIDS*, Module 5: Prisons, pp. 30-32.

659 See *Legislating for Health and Human Rights: Model Law on Drug Use and HIV/AIDS*, Module 5: Prisons, pp. 25-30.

(2) Wherever possible, sterile syringes and related material shall be made available to prisoners without the necessity of the prisoner identifying himself or herself to prison authorities.

(3) The Ministry of Justice, in consultation with the Ministry of Health shall establish rules for the safe storage of syringes possessed by prisoners in accordance with this law.

(4) The sterile syringe programme shall include measures to encourage safe disposal of syringes and monitor the number of syringes distributed and the number in storage.

(5) Sterile syringes and related material distributed by harm reduction programmes shall be used only in accordance with this law and any other applicable Regulations or institutional policies established by the relevant authority.

(6) The distribution and possession of syringes and related material in prison in accordance with this law shall not constitute a criminal nor administrative offence, nor shall such items be admissible as evidence of illegal drug use for the purposes of determining any criminal or administrative offence.

Availability of bleach as a disinfectant

(1) Bleach and instructions on using bleach as a disinfectant shall be made available in accordance with this law and any other applicable Regulations or institutional policies established pursuant to this law.

(2) Any such Regulations or policies established pursuant to Section (1) will:
(a) encourage participation of prisoners and their assistance in bleach distribution;
(b) ensure that bleach is available to prisoners in ways that preserve prisoners' anonymity; and
(c) ensure that in no instance shall a prisoner be required to approach a staff member in order to obtain bleach.

(3) Bleach distributed pursuant to this law shall be used only in accordance with this law and any other applicable Regulations or institutional policies established pursuant to this law.

(4) The distribution and possession of bleach in prison in accordance with this law shall not constitute a criminal nor administrative offence, nor shall such items be admissible as evidence of illegal drug use for the purposes of determining any criminal or administrative offence.

Recommendation 28: Provide information on HIV in prisons

The national expert group has recommended complementing Article 71 of the *Penal Code* (rules of admission of prisoners) with a sub-paragraph on obligatory briefing of prisoners about the possibility of free, confidential HIV testing. The wording could be the following:

Information and education programmes regarding HIV/AIDS, other blood-borne diseases and drug dependence treatment in prisons

(1) The Ministry of Health shall develop and implement information and education programmes in every prison to help prevent the spread of HIV, other blood-borne diseases, and to address drug dependence among prisoners.

(2) In developing such programmes, the Ministry of Health shall use materials that are likely to be effective in reducing transmission of blood-borne diseases within prisons and outside prison following the release of prisoners, as well as providing information on treatment, care and support.

(3) Such programmes required by Section (1) may include peer education and use of non-Ministry of Justice personnel, including delivery of these programmes by community-based organizations.

(4) Materials shall, as much as possible, be available in the languages of the relevant populations, shall take into account the literacy level of the relevant populations, and shall be sensitive to the social and cultural needs of the relevant populations.

Responsibility of the Ministry of Health for providing training and education

The Ministry of Health is responsible for ensuring:

(a) that training and education are provided to staff and prisoners on a regular basis, and that such training and education include the principles of standard precautions to prevent and control blood borne diseases; the personal responsibility of staff and prisoners to protect themselves and others at all times; and information on post-exposure prophylaxis, if available;

(b) that training and education provided to prisoners also include available services and treatments; and peer education and counselling programmes that include the meaningful participation of prisoners as counsellors; and

(c) that prisoners and staff who may be exposed to blood and body fluids receive training in universal precautions.

Recommendation 29: Ensure access to personal hygiene items for women prisoners

The national expert group has also recommended that Article 93.3 of the *Penal Code* be amended to oblige penitentiary institutions to ensure that women in prison have access to the necessary items for personal hygiene (and amend the Resolution of the Cabinet of Ministers No. 154 of 25 September 2001 accordingly). The wording could be as follows:

For the purpose of improving the sanitary and hygienic conditions of women in detention, and to assist with HIV prevention among women in detention, penitentiary institutions shall supply women in custody with necessary personal hygiene items.

Recommendation 30: Ensure access to treatment for prisoners with HIV

To ensure the right of access to equivalent health services, authorities responsible for correctional facilities need to implement universal access to antiretroviral therapy and other needed medications and treatment for HIV-positive prisoners. This obviously requires more than mere legislative amendments, but one important step would be to create a clear legal provision that recognizes prisoners' rights in this area. To this end, a provision such as the following should be inserted into the *Law on prevention of HIV and AIDS* and/or the *Penal Code*:[660]

Right to equal and adequate health care for prisoners

(1) HIV testing for prisoners is conducted only on a voluntary basis.

(2) A prisoner who has tested positive for infection with HIV is entitled to adequate health care, counselling and referrals to support services while in prison.

(3) Health practitioners shall provide prisoners with protection of their physical and mental health and treatment of disease of the same quality and standard as is afforded to those who are not imprisoned or detained.

While it is recommended that there be explicit reference to HIV, ideally, such an amendment would be worded more broadly to extend to needed health care services and medications beyond just HIV-specific care.

660 See *Legislating for Health and Human Rights: Model Law on Drug Use and HIV/AIDS*, Module 5: Prisons, pp. 16-17.

Recommendation 31: Protect confidentiality of prisoners' health information

The national expert group has recommended amendments to the *Penal Code,* including adding provisions regarding the obligation on prison system personnel to maintain the confidentiality of medical information of prisoners, including their HIV status. A provision such as the following should be inserted into the *Penal Code*:

> **Confidentiality**
>
> (1) All information on the health status and health care of a prisoner is confidential, and all health care procedures shall be designed so as to preserve the confidentiality of prisoners.
>
> (2) Information referred to in Section (1) shall be recorded in files available only to health practitioners and not to non-health care prison staff. No mark, label, stamp or other visible sign shall be placed on prisoner's files, cells or papers that could indicate his or her HIV status, other than necessary notations inside the medical file in accordance with standard professional practice for recording clinically relevant information about a patient.
>
> (3) Information referred to in Section (1) may only be disclosed:
> (a) with the prisoner's consent; or
> (b) where warranted to ensure the safety of other prisoners or staff;
>
> with the same principles as generally applied in the community applying to the disclosure.

Recommendation 32: Continuity of HIV treatment and care after release from prison

The national expert group has recommended including in Article 175 of the *Penal Code* a paragraph with the following language:

> After release of a prisoner with HIV, said release should be reported in a confidential order to a corresponding health care facility, which should extend all possible assistance to such person.

Recommendation 33: Eliminate discrimination against prisoners with HIV or drug dependence

To eliminate discrimination currently embedded in the law, the *Penal Code* should be amended in a number of ways, as follows:

- Repeal the prohibition on transferring prisoners who are ordered to undergo compulsory drug dependence treatment to better conditions (lower security institutions).
- Remove HIV-positive status and the fact of not completing a full course of treatment for drug dependence or STIs from Articles 80 and 100 (and others as follows) as factors that restrict a prisoner's right to transfer and movement.
- Although it is reportedly not enforced at the moment, Article 78, which provides for the segregation of HIV-positive prisoners, is discriminatory; it should be abolished.

Recommendation 34: Treatment of tuberculosis in prisons

The national expert group has underlined the importance of effective programmes of tuberculosis treatment and prevention in penitentiary institutions, and recommended developing procedures for assessment of effectiveness and strict control over compliance with governmental standards and procedures in the sphere of TB treatment in the penitentiary.

Discrimination

As noted above, legislation of Azerbaijan includes provisions prohibiting, in general terms, violation of equality of people based on HIV-positive status. The *Law on prevention of HIV/AIDS* prohibits "dismissal from job, refusal to employ or enroll to preschool or educational institutions, or provide health care service, and restriction of other rights and interests of people living with HIV and members of their families based on the disease".[661] Article 8 of the *Law on prevention of physical disability, rehabilitation and social protection of the disabled* is devoted to protection of rights, freedoms and legitimate interests of persons with disabilities and prohibits any discrimination against them. Yet at the same time, discrimination is a reality and the law itself contains discriminatory provisions in other areas. Legal protections against discrimination are important elements of successfully addressing the marginalization that contributes, in multiple ways, to people's vulnerability to HIV and to experiencing even more severely the impact of HIV infection. Azerbaijani law can be strengthened in several ways in this regard in order to comply with human rights principles. The recommendations below would help achieve this.

Recommendation 35: Eliminate HIV testing in employment or educational settings

It would be useful to recognize explicitly that requiring HIV testing before or during employment or attendance at an educational institution amounts to unjustified discrimination, which discrimination is already prohibited, in general terms, by the law.[662] A legislative amendment to the *Law on prevention of HIV and AIDS* should prohibit such practices. A provision could be worded as follows:

> Discriminating against a person on the basis of his or her HIV infection or AIDS diagnosis is prohibited, including but not limited to such contexts as employment or education. It is unlawful discrimination to require that a person be tested for HIV as a condition of employment or enrolment in an educational institution, either before or during employment or enrolment.

Recommendation 36: Eliminate discrimination against drug-dependent persons in employment or educational settings

Requiring drug testing *before* employment or enrolment in an educational institution is also unjustified discrimination based on health condition. Requiring testing for drug use *during* employment may only be potentially justifiable in quite limited circumstances, such as limiting testing to positions that are safety-sensitive and then only in cases where there are reasonable grounds to suspect impairment or possibly random drug testing of persons returning to work after receiving drug dependence treatment. To eliminate unjustified discrimination, a number of steps are recommended.

First, it is recommended that the law — perhaps the *Law on narcological service and control* — include a provision along the lines of the following:[663]

> **Discrimination based on drug use**
>
> (1) Absent a reasonable justification given the circumstances of the case, it is prohibited to discriminate against a person, or a relative or associate of the person, on the ground that the person uses or has used drugs, or is perceived to use or have used drugs.
>
> (2) It is unlawful discrimination to require that a person undergo drug testing as condition of enrolment in an educational institution, either before or during enrolment.

661 *Law on prevention of HIV and AIDS*, Article 10.

662 E.g., see UNAIDS/OHCHR, *International Guidelines on HIV/AIDS and Human Rights*, para. 149. Similar analysis would apply to discrimination against someone based on something like infection with hepatitis B or C virus (HBV, HCV) or on the basis of a sexually transmitted infection. Given modes of transmission, many people who inject drugs are vulnerable to infection with other blood-borne diseases such as HBV or HCV, in addition to HIV, and may face discrimination on that basis, as has been observed in other jurisdictions. In making amendments to strengthen protection against HIV-related discrimination in an area such as employment or educational contexts, it would be advisable to explicitly include protection against discrimination based on such other diseases.

663 See *Legislating for Health and Human Rights: Model Law on Drug Use and HIV/AIDS*, Module 7: Stigma and discrimination, pp. 13-15.

(3) It is unlawful discrimination to require that a person undergo drug testing as a pre-condition of employment. Making drug testing a condition of continued employment is permitted only in positions, as designated by [suitable government authority], where impairment while at work may pose a significant risk of harm to the individual employee or to others and where there are reasonable grounds to suspect that the individual employee may be impaired by drug use.

Second, it is also recommended to review the list of 18 occupations that require pre-employment drug testing, which list is defined by the Decision of the Cabinet of Ministers of Azerbaijan. It is recommended to begin a consultation process with policy-makers and to study experiences of other countries for models of legislation that limits restrictions on permitted occupations based on drug use only in specific cases defined in the law and based on individual assessments of ability to perform.

Recommendation 37: Drug dependence as a disability

Azerbaijani law includes a positive provision recognizing that drug dependence can be considered a disability for certain purposes (i.e., entitlement to social benefits). However, as the national expert team noted, there are no documents that clearly outline when drug dependence is recognized as a disability under the law. Having a clear standard in this area would help address the marginalization and poverty of (some) people who use drugs and would help promote health, including their success with drug dependence treatment and social reintegration.

Recommendation 38: Respect and protect family relationships

As noted above, current law states that mere HIV-positive status can be a basis for denying someone's application to adopt a child; this blanket discrimination simply on the basis of a health condition, without regard for individual circumstances, is not justified. Similarly, there is cause for concern that, under the law, someone's drug dependence could be assumed to be *per se* a reason for depriving him or her of parental rights (custody of a child) in cases of concern about child abuse or neglect, rather than an individualized assessment. It is recommended that:

- Article 64 of the *Family Code* should be amended to clarify that, in cases of concern about child abuse or neglect, drug dependence should not be assumed to be *per se* sufficient grounds to deprive someone of parental rights, but rather than a careful analysis of the individual circumstances is required.
- The Government resolution that lists HIV and drug dependence as barriers to adopting or receiving custody of a child should be amended to delete these diseases from the list.

KAZAKHSTAN

SUMMARY REPORT AND RECOMMENDATIONS

KAZAKHSTAN: SUMMARY REPORT AND RECOMMENDATIONS

1. BACKGROUND

Kazakhstan is the ninth largest country in the world by landmass, but with a population just under 15.6 million.[664] It borders China, Kyrgyzstan, Turkmenistan, Uzbekistan, and the Russian Federation. Astana, the capital as of December 1997, has a population of approximately 550,000 people. Kazakhstan is a unitary state with three branches of government: legislative authority is vested in Parliament; the executive branch consists of central bodies (Ministries, Departments and Agencies) and local bodies (Akimats); and judicial authority rests with the Supreme Court and local courts.

As of the beginning of 2008, official records indicated 9379 people with HIV in the country (62 per 100,000 people, a prevalence rate under 1 percent). The epidemic is concentrated largely among groups with high-risk activities, primarily injecting drug users and prisoners. Injecting drug use is currently the primary driver of the epidemic in Kazakhstan, accounting for 66% of all cases.[665] 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.[666]

664 Statistics Agency of the Republic of Kazakhstan (March 2008), online: www.stat.kz/RU/digital/Pages/default.aspx.
665 UNAIDS, *Eastern Europe and Central Asia: 2007 AIDS epidemic update: regional summary* (Geneva: UNAIDS, 2008), p. 7.
666 Sentinel Epidemiological Surveillance Report (2007), National AIDS Centre.

2. NATIONAL PROGRAMMES AND STRATEGIES

Programme on HIV/AIDS

In 2000, the Government adopted its "Policy Concept on Measures against AIDS in the Republic of Kazakhstan."[667] It defined priorities in HIV prevention, with a focus on vulnerable population groups (injecting drug users, sex workers and men having sex with men). Under this Concept, the second National AIDS Programme in the Republic of Kazakhstan for 2006-2010 was adopted in 2006 with a total budget of approximately 7 billion KZT (approximately USD 56 million), 60% of which is allocated for prevention efforts. The programme is implemented by the Ministry of Health.[668] The National AIDS Programme includes such HIV prevention measures as condom distribution to sex workers, syringe exchange programmes, the development and dissemination of awareness-raising materials and, in the oblast and city AIDS Centres, free HIV and STI testing (described simultaneously as "anonymous/confidential" without a clear distinction) and treatment.[669]

As of December 2008, there were 22 AIDS centres in the country, comprising the National AIDS Centre and oblast and city AIDS centres. These centres implement HIV prevention, diagnosis and treatment measures. A doctor is appointed in the central district (*rayon*) hospital with responsibility for HIV prevention measures among rural people, as well as timely diagnosis of cases of HIV infection and AIDS.[670]

For the purposes of involving people living with HIV and civil society representatives in the implementation of the National AIDS Programme, HIV prevention organizations are supported through the government procurement of social services, international organizations fund a permanent forum of HIV prevention NGOs, and NGOs' personnel capacity is strengthened through yearly training of NGO staff on monitoring and analysis of measures against AIDS.

For purposes of securing grants from the Global Fund to Fight AIDS, Tuberculosis and Malaria, a Country Coordinating Mechanism (CCM) was established in Kazakhstan in 2005. The national expert group has reported that almost half CCM's members are representatives of civil society, including people living with HIV.

Programme on drug control

The current national *Strategy of counteracting drug addiction and drug trafficking in the Republic of Kazakhstan for 2006-2014* was adopted by presidential decree in 2005.[671] The national expert group reports that representatives from non-governmental organizations (NGOs) participated in the development of the strategy. The strategy outlines the following key areas of activity:

- reducing drug demand (through effective primary prevention of drug misuse);
- treatment and rehabilitation of people who misuse drugs;
- reducing drug supply (through suppression of illicit traffic of narcotic drugs, psychotropic substances, and precursors); and
- effective control of licit drug circulation regulated by the state.

The *National Programme on Combating Drug Dependence and Drug Trafficking for 2006-2008* was adopted in April 2006 as the first stage of implementing the national strategy on drugs.[672] The implementation of the National Programme is coordinated by the Drug Enforcement Committee of the Ministry of Internal Affairs of Kazakhstan. According to the national expert group, the programme is based on a multi-sectoral approach with cooperation of all stakeholders, including NGOs. In addition to existing services for drug dependent people (narcological service) the National Programme aims to implement the following measures: a hotline counselling service for drug users; social and psychological rehabilitation of people with drug dependence following treatment. The national expert group has noted that effective implementation of the National Programme in many ways depends on funds that are allocated. The experts also underlined the necessity to improve coordination between law enforcement bodies and those agencies, both governmental and NGOs, implementing services within the frame of the National Programme. To this end, they have recommended that the Ministries of Internal Affairs, Justice and Health adopt a joint order that would protect workers of harm reduction programme and would facilitate greater coverage of people who use drugs by harm reduction services.

Results of a survey of stakeholders conducted by the national expert group

- As part of this project, in 2007 the Kazakh national expert group conducted a survey of stakeholders soliciting input for evaluating the effectiveness of national programmes on HIV prevention and treatment among vulnerable populations.[673] The opinions of respondents are presented below. 50% of IDU respondents and 52.5% of prisoners identified a need for improving education on HIV among IDUs and prisoners.
- 100% of IDU respondents thought it is necessary to provide drug treatment services and implement rehabilitation programmes for IDUs anonymously, as confidentiality of such services is not actually observed.
- 75.2% of respondents thought that the registration of drug users should be cancelled, as it leads to restriction of rights, such as employment problems, discrimination by law enforcement officers, and efforts to force drug users to cooperate with law enforcement bodies under the threat of charging them with drug possession.
- 5% of prisoners noted that they continued to use drugs in prisons and 8.8% indicated that it is possible to obtain drugs in prisons, leading this category of respondents to conclude that it is necessary to introduce harm reduction programmes (including opioid substitution treatment) in prisons.
- Most respondents considered it necessary to combine harm reduction programmes with treatment for drug dependence and incentives for clients to participate in medical and social rehabilitation programmes. Apart from regular services (e.g. HIV education; distribution of syringes, condoms and disinfectants; testing and referral for other health care services), the services of psychologists, psychotherapists and narcologists should be provided.
- Respondents emphasized the need to introduce opioid substitution treatment (OST) for opioid users.
- Respondents stressed that it is necessary to amend Kazakh law to prohibit discrimination against people with HIV and people who use drugs by the representatives of all institutions with which they have been in contact (e.g., health care professionals, law enforcement officers, etc.) and other members of society. These amendments should allow for punishment in cases of discrimination and stigmatization with respect to these vulnerable groups.

People living with HIV, people who use drugs and those released from correctional facilities need social services.

667 Government of Kazakhstan, Resolution No. 1808 (5 December 2000).

668 The *National Programme on counteracting AIDS epidemic in the Republic of Kazakhstan for 2006-2010* [Государственная Программа по противодействию эпидемии СПИДа в Республике Казахстан], Government of Kazakhstan, Resolution No. 1216 (15 December 2006).

669 This activity is carried out by "friendly cabinets" [дружественные кабинеты], and is regulated by the Order "On Friendly Cabinets", Order No. 295 (29 March 2006), which was adopted on the basis of the National AIDS Program in the Republic of Kazakhstan for 2006-2010.

670 Order "On AIDS Centres Activity", Order No. 286, para. 2 (HIV Prevention in Rural Areas).

671 Strategy of counteracting drug addiction and drug trafficking in the Republic of Kazakhstan for 2006-2014 [Стратегия борьбы с наркоманией и наркобизнесом в Республике Казахстан на 2006-2014], adopted by President of Kazakhstan, Decree No. 1678 (29 November 2005).

672 National program on combating drug dependence and drug trafficking for 2006-2008, [Государственная программа борьбы с наркоманией и наркобизнесом на 2006-2008 годы], Resolution of the Government of Kazakhstan, No. 240 (5 April 2006).

673 The survey questioned a total of 351 respondents, among which there were: 80 people who inject drugs; 67 people living with HIV; 67 sex workers; 80 prisoners; 53 outreach workers; and 71 health care professionals.

3. ADMINISTRATIVE AND CRIMINAL LAW PROVISIONS ON NARCOTIC DRUGS

Kazakhstan has a separate Law "On Narcotic Drugs, Psychotropic Substances, Precursors and Their Illicit Traffic and Abuse Countermeasures" [hereinafter Law "On Drugs"].[674] This legislation sets out general prohibitions; criminal and administrative codes (described below) define offences and associated punishments. Under the Schedules adopted according to the Law "On Drugs", distinctions are drawn between "small" [небольшие], "large" [крупные] and "extra large" [особо крупные] quantities of narcotic and psychotropic substances.[675] These quantities are relevant to determining whether certain prohibited acts amount to administrative or criminal offences, as described further below. For example, offences involving "large" and "extra large" amounts of drugs without intention of sale lead to criminal liability,[676] as does any sale of narcotic drugs and psychotropic substances regardless of quantity.

In 2008 Kazakhstan toughened its drug legislation.[677] The new legislation introduced 20 year imprisonment and life sentence for certain drug offences. Punishment from 20 years to life imprisonment was introduced for trafficking of drugs (Article 250.4); illicit purchase, transportation or possession with intention of sale, or manufacturing, processing, mailing or sale of drugs if committed by an organised or criminal group, in an educational institution or in relation to a minor (Article 259.4); stealing or extortion of drugs in extra-large amount (Article 260.4); incitement to use drugs when it by negligence led to death of a person or other serious consequences (Article 261.4).

Under Kazakh law, the age at which a person can be held administratively or criminally responsible for drug-related offences is 16.

Administrative liability

The use of drugs *per se* is not prohibited under Kazakh law, but drug use "in public places" is an administrative offence under the *Code of Administrative Offences*.[678] A repeat offence within a year triggers a higher penalty.[679]

In addition, a person may be held administratively liable (and punished by fine) for avoiding medical examination and treatment if he or she is recognized as drug-dependent, or if there is "sufficient information" on his or her use of narcotic drugs or psychotropic substances without a physician's prescription.[680]

The *Code of Administrative Offences* also creates the following administrative offences punishable by fines:

- failure to exterminate wild cannabis (Article 318);
- failure to maintain the security of drug plantings (Article 319);
- failure to take measures against trafficking and use of drugs, psychotropic substances, and precursors (by official or owner of entertainment facility) (Article 319-1);
- illicit production, purchase or possession of drugs *without intention of sale* "in a quantity that does not fall under criminal law" (i.e. "small" amounts) (Article 320);
- propaganda and advertising malpractice with respect to drugs, psychotropic substances, and precursors (Article 321).

674 Law "On Narcotic Drugs, Psychotropic Substances, Precursors and Their Illicit Traffic and Abuse Countermeasures", [О наркотических средствах, психотропных веществах, прекурсорах и мерах противодействия их незаконному обороту и злоупотреблению ими], Law No. 279-I (10 July 1998).

675 See Appendix 1 for Table 2**.** *Threshold amounts of selected controlled psychoactive substances triggering criminal or administrative liability* . Kazakhstan has very low thresholds for defining quantities of drugs as "small" (e.g., <0.01g of heroin), "large" (e.g., 0.01-1g of heroin) and "extra large" (e.g., >1g of heroin). In fact, Kazakhstan's schedules are the strictest in Central Asia.

676 Criminal Code of the Republic of Kazakhstan, No. 167-1 (16 July 1997).

677 Law of the Republic of Kazakhstan, "On amendments and changes in the Criminal Code, Code of Criminal Procedure, and Code of Administrative Offences in relation to strengthening sanctions for illegal trafficking of drugs" ["О внесении изменений и дополнений в Уголовный, Уголовно-процессуальный кодексы Республики Казахстан и Кодекс Республики Казахстан об административных правонарушениях по вопросам усиления ответственности в сфере незаконного оборота наркотиков»], No 50-IV ЗРК (27 June 2008).

678 Code of Administrative Offences, Law No. No. 155-2 (30 January 2001), Article 336-2. A person may be held liable for an administrative offence as of the age of 16 under Kazakh law.

679 Ibid.

680 Code of Administrative Offences, Article 326.

Criminal liability

The *Criminal Code* prohibits the following activities:

- Involvement of minors in drug use is punishable by communal works for 180-240 hours, or correctional works for the term of one to two years, arrest for the term of up to six months, or imprisonment for up to three years (Article 132).
- Illicit purchase, transportation or possession of drugs or psychotropic substances *without intention of sale* in "large" quantities is punishable with a fine, communal work of up to 200 hours or correctional labor for up to two years, or imprisonment for up to three years (Article 259.1).
- Illicit purchase, transportation or possession of drugs and psychotropic substances *without intention of sale* in "extra large" quantities is punishable with imprisonment for three to seven years with confiscation of property (Article 259.1-1).
- Illicit purchase, transportation, possession *with intention of sale*, production, processing, mailing or sale of drugs or psychotropic substances is punishable with imprisonment for five to ten years with confiscation of property (Article 259.2). The same offence committed in relation to "large" quantities of a prohibited substance is punishable with imprisonment from six to 12 years with confiscation of property (Article 259.2-1).
- Illicit purchase, transportation, possession *with the intention of sale,* manufacturing, processing or mailing of drugs and psychotropic substances, when committed by a group, repeatedly, in "extra large" quantities, or by an official abusing his or her official position is punished with imprisonment for ten to fifteen years with confiscation of property (Article 259.3). The same offence committed by an organized or criminal group, in an educational institution, or in relation to a minor, is punishable with imprisonment for fifteen to twenty years with confiscation of property, or life imprisonment (Article 259.4).
- Cultivating banned plants containing drugs is punishable by a fine, or imprisonment for up to two years. The same offence committed by a group, repeatedly or in large quantities is punishable by imprisonment for three to eight years (Article 262).
- Organizing or maintaining premises for the use of narcotic drugs or psychotropic substances, or allowing premises to be used for the same purposes, is punishable by imprisonment for a term of three to seven years with confiscation of property (Article 264). The same offence committed using one's official capacity, repeatedly or by organized group leads to imprisonment from seven to twelve years with confiscation of property (Article 264).
- Incitement to use narcotic drugs or psychotropic substances is punishable by limitations of freedom[681] for up to 3 years, "arrest" for up to 6 month, or imprisonment for up to four years. If incitement to drug use has negligently led to death of the person or other serious consequences, it leads to imprisonment from 15 to 20 years, or life sentence, both with confiscation of property (Article 261).
- Infringing the rules governing the production, processing, purchasing, keeping, accounting, delivery, transportation, importation, exportation, transferring or eradication of drugs, if such act is committed by a person responsible for complying with those is punishable by a fine or "corrective works" for a term of up to 1 year, or imprisonment for the term of up to one year (Article 265).

Being intoxicated during the commission of a crime is an aggravating circumstance, although depending on the nature of crime, a court has the discretion not to treat it as such.[682]

Sterile needle and syringe programmes: legal issues

Under Kazakh law, the possession of implements for drug use (e.g., syringes, disinfectants, other implements) is not a punishable act. However, there are concerns that harm reduction services and their personnel (e.g., outreach workers) are not clearly protected against liability for their work, which seeks to ensure that people who use drugs do so in ways that reduce the risks of harm, including HIV infection. In particular, the law should make clear that those operating syringe exchange programmes are not targeted

681 According to Article 45 of the Criminal Code, "limitation of freedom" means subjecting a person to specific obligations limiting one's freedom, during a term served in the place of one's residence, with supervision of specialised law enforcement facility, without isolation from society, for a period of one to five years. According to Article 46 of the Criminal Code, "arrest" means strict isolation from society during the entire period of the sentence, and is imposed for a period of one to six months.

682 Criminal Code, Article 54.

under either the "propaganda and advertising" provisions of the Law "On Drugs" (Article 24) and the *Code of Administrative Offences* (Article 321), or the "incitement of drug use" provision of the *Criminal Code* (Article 261), as described above.

Compulsory drug testing

Compulsory medical examination and drug testing may be conducted either (1) in relation to specific professional activities,[683] or (2) in situations of drug use in public places, which is considered an administrative offence.[684] According to an order from the Ministry of Health, compulsory drug testing is carried out with respect to persons in a state of intoxication "in public places, at work, etc."[685] Traffic police, district police inspectors and other officers under the Ministry of Internal Affairs, as well as management of the enterprises and organizations in which a person works, are entitled to refer a person to medical examination. Medical examination and drug testing is carried out by narcologists in specialized narcological facilities or other trained medical doctors.[686]

Although the law does not provide that drug use or being under the influence of drugs is *per* se an offence,[687] the *Code of Administrative Offences* (Article 326) imposes administrative liability, in the form of fines, for "avoidance of medical examination and treatment by the persons with diagnosis of drug or alcohol dependence, or in relation to whom there is "adequate data" [достаточные данные] that they use drugs and psychotropic substances without prescription." Effectively, therefore, Kazakh law gives police considerable powers to impose compulsory testing for drugs on a wide range of people.

According to the Law "On Drugs", a person who is under the influence of drugs, or about whom police, public health bodies or other responsible bodies receive information that s/he uses illicit drugs, must undergo medical testing. The fact of illicit drug use is determined on the basis of witness statements, signs of being under influence of drugs, and the results of testing.[688]

However, such wide provisions on compulsory drug testing, vesting such extensive powers in law enforcement bodies, represent not only an inefficient use of limited resources but also an unjustified intrusion on human rights. For example, subjecting someone who has not committed any offence to involuntary drug testing violates the rights to liberty, security of the person and privacy, as well as the right to be free from non-consensual medical intervention; if test results are also used against the person in any sort of prosecution, it would also violate the right against self-incrimination.[689] The only possible bases on which it might be justifiable for the state to infringe such human rights would be to intervene to prevent a serious risk of harm to oneself or to others; mere use of alcohol or drugs does not, by itself, establish this.

Other vulnerable groups: criminal and administrative law issues

Sex work

Sex work is not administrative or criminal offence in Kazakhstan, which is a positive development. Involvement in sex work using threats, coercion or violence[690], organising and maintenance of brothels, and pimping[691] are criminal offences, punishable by fines, or imprisonment for up to three years. If organising of brothels or pimping is committed by organised group, or a person who earlier committed the same offence, the punishment is stricter (imprisonment for up to five years).[692] This position taken by Kazakh legislators is based on international human rights standards and is more informed by best practices, than situation in other countries of the region (with the exception of Kyrgyzstan)

STI and HIV transmission and exposure

- Transmission of STI which lead to grave consequences, infecting two or more people, or a minor by someone who knew of his/her STI infection – is punishable by fine, or imprisonment for two years.[693]
- Knowingly exposing someone to HIV, is punishable by limitation of freedom for up to three years, imprisonment for up to one year.
- HIV transmission by someone who knew of his/her HIV infection is punishable by imprisonment for up to five years. HIV transmission by someone who knew of his/her infection to two or more people or minor –is punishable by imprisonment for up to eight years.
- Transmission as a result of negligent performance of one's professional duties by health care professionals or other service providers is punishable by imprisonment for up to five years and prohibition to hold certain positions for up to three years.[694]

The *International Guidelines on HIV/AIDS and Human Rights* recommend against such an approach: criminal legislation should not include specific offences regarding HIV transmission or exposure.[695] Having a specific criminal offence singling out HIV exposure and negligent HIV and STI transmission, runs contrary to internationally recommended policy, in part because it stigmatizes people living with HIV, and people vulnerable to it, and creates a further disincentive for HIV testing and an additional barrier to access to health services.

683 E.g., transport drivers and small ship operators: "Rules on Referral for Intoxication Examination, and Reporting on its Results", Government of Kazakhstan, Resolution No. 528 (4 June 2003), Article 1.

684 Code of Administrative Offences, Article 336-2.

685 Ministry of Health, "Instructions on Medical Examination for Fact-Finding of Psychoactive Substance Use and Intoxication", [Инструкция по проведению медицинского освидетельствования для установления факта употребления психоактивного вещества и состояния опьянения], Order No. 446 (11 June 2003).

686 Presidential Decree bringing into force the Law "On Bodies of Internal Affairs of the Republic of Kazakhstan"; and Code of Administrative Offences.

687 As noted above, however, according to the Code of Administrative Offences, a person is administratively liable for driving under the influence of drugs or alcohol (Article 629) and for drug use "in public places" (Article 336-2).

688 Law "On Drugs", Articles 32-33.

689 International Covenant on Civil and Political Rights, 999 U.N.T.S. 171 (1966), Articles 7, 9, 14, 17.

690 Criminal Code, Article 270.

691 Ibid., Article 271.

692 Ibid.

693 Criminal Code, Article 115.

694 Ibid., Article 116.

695 Joint United Nations Programme on HIV/AIDS & Office of the High Commissioner for Human Rights, International Guidelines on HIV/AIDS and Human Rights, Guideline 4, para. 21(a); UNAIDS, Policy Brief: Criminalization of HIV Transmission (2008).

4. HEALTH SYSTEM AND SERVICES

The Constitution of the Republic of Kazakhstan states that Kazakh citizens have a right to receive free medical care provided for by the law.[696] This constitutional provision was supplemented by the Law "On Public Health Care",[697] which states the following basic principles of state health care policy:

- access to medical care for the population independent of social and property status;
- social justice and equality of citizens in the provision of medical care; and
- state responsibility for ensuring conditions that guarantee health care and health promotion.

The key objectives of the state health care policy are to provide Kazakh citizens with "free guaranteed medical care" and to implement measures to protect the health of vulnerable groups within the population. Citizens also may get medical care for which they pay privately and may use voluntary health insurance services. Specialist services are provided only to Kazakh citizens based on *de facto* residence and proving their identity with the official identity card. Stateless persons and foreigners are provided only with free emergency medical care.[698]

According to Kazakh law "free guaranteed medical care" includes:

- primary health care;
- accident and emergency health care;
- in-patient medical care upon referral by primary health care specialists; and
- health care for people with "socially significant diseases and diseases which represent a serious hazard to others".[699]

4A. DRUG DEPENDENCE TREATMENT

Access to drug dependence treatment for people with drug dependence is free, as "narcological diseases" are classified as "socially significant diseases".[700]

There is no one single statute on drug dependence treatment in Kazakhstan. The rules of medical and social rehabilitation are stated in the Law "On medical and social rehabilitation of people with drug dependence".[701] Provisions regulating compulsory drug dependence treatment are specified in the Law "On Compulsory Treatment of Alcohol, Drug, and Toxic Substances Abuse".[702] The Law "On Drugs" contains provisions for the detection, testing, treatment and rehabilitation of people with drug dependence.[703]

Drug dependence treatment is abstinence-oriented and consists of detoxification and complex psychotherapy.[704] Treatment can be delivered on both outpatient and inpatient bases.[705] Drug dependence treatment can be provided by any health care facility with a license for this type of activity, whether publicly or privately owned.

Standards for diagnosis and treatment of drug dependence are specified in protocols approved by the Ministry of Health.[706] Among other things, these protocols provide for medical and social rehabilitation in inpatient drug rehabilitation facilities. However, according to the national expert group, there are no protocols and practice of outpatient rehabilitation and aftercare.

Opioid substitution treatment

Kazakhstan has only recently begun to implement opioid substitution treatment (OST). The programme of OST has been formalized in the national programme on HIV and other documents since 2004; two pilot projects for 50 people started in November 2008. Government regulations recommend focusing on people living with HIV as a priority population when implementing OST, as a way of assisting compliance with anti-retroviral treatment regimens.[707]

In 2004, the National AIDS Centre contracted with "Rusan Farma", an Indian pharmaceutical manufacturer of methadone; of a total contract worth USD 52,704, as of 2008 USD 10,540 had been paid.

At a meeting on 26 September 2005 chaired by the Minister of Health, it was decided to introduce a pilot OST project to provide methadone for 50 HIV-positive people who inject drugs. In December 2005, the Minister of Health signed an order "On Substitution Therapy", according to which, in 2006, the OST pilot programme was to be implemented for 50 heroin-dependent people with HIV in Pavlodar and Karaganda (25 patients in each city).[708] On 13 March 2006, the Ministry of Health approved the "Guidelines on Methadone Use for Drug Treatment and Harm Reduction Programmes". In October 2006, the Government adopted a resolution on a quota of methadone for the pharmaceutical procurement in 2006.[709] In 2006-2008, various steps were taken to import methadone into the country, and in November 2008 two pilot projects started in Pavlodar and Temirtau (25 people in each).[710]

Kazakhstan's legislation does not require a special license for OST programmes, as their implementation falls within the category of "outpatient or inpatient narcological service". Health care facilities should obtain a license to work with controlled narcotic drugs. That license is issued by the Pharmaceuticals Board of the Ministry of Health and is approved by the Drug Enforcement Committee under the Kazakh Ministry of the Interior.

OST is a proven, effective method of drug dependence treatment. There is ample data demonstrating the importance of OST programmes for HIV prevention among people who use illegal opioids, as well as for improving the quality of life of patients and reducing illegal drug use and drug-related crime.[711] After assessing the effectiveness of the OST pilot projects in Kazakhstan, the Government should consider scaling up the treatment and extending such programmes into prisons as soon as possible.

696 Constitution of the Republic of Kazakhstan (30 May 1995), Article 29.

697 Law "On Public Health Care" [О системе здравоохранения], No. 430-2 (4 June 2003), Article 3; Law "On Health Protection" [Об охране здоровья граждан], Law No. 170-III (7 July 2006), Article 3.

698 Law "On Public Health Care", Law No. 430-2 (4 June 2003).

699 See the Law "On Health and Disease Control", Law No. 361-II (4 December 2002), as subsequently amended by Law No. 13-III (20 December 2004).

700 Government of Kazakhstan, Resolution No. 468 (30 March 2000), para. 14 (List of socially significant diseases and diseases of serious hazard to others).

701 Law "On medical and social rehabilitation of people with drug dependence" [О медико-социальной реабилитации лиц, больных наркоманией], Law No. 325-II (27 May 2002).

702 Law "On Compulsory Treatment of Alcohol, Drug, and Toxic Substances Abuse" [О принудительном лечении больных алкоголизмом, наркомании и токсикоманией], Law No. 2184 (7 April 1995).

703 Law "On Drugs" Chapter 3 (Medical and Social Care for Drug and Toxic Substances Addicts), Articles 32-37.

704 Ministry of Health, Order "On the Rules of Drug-dependents Referral, Care and Extent of Medical Aid in Medical and Social Rehabilitation Centres (departments)" [Об утверждении Правил направления лиц, больных наркоманией, условиях содержания и объеме помощи больным, страдающим наркоманией, в центрах (отделениях) медико-социальной реабилитации], Order No. 638 (18 August 2004).

705 Ministry of Health of Kazakhstan, Order "On Approval of the Statute on Drug Treatment Facilities (hospitals, dispensaries, centres, departments" [Об утверждении Положения о наркологических организациях (больницах, диспансерах, центрах, отделениях], Order No. 637 (18 August 2004).

706 Ministry of Health, Order No. 655 (30 December 2005).

707 Ministry of Health, Order No.150 (12 February 2004), para. 1.5: "Methadone Substitution Treatment as a health care service to people living with HIV. "Those medical treatment facilities which have or plan to get a permission to prescribe on methadone substitution treatment shall provide HIV treatment and distribute medicines among their patients. In this case, maximal control over ART [anti-retroviral therapy] is achieved, which is required for improving its effectiveness and reducing the risk of HIV developing drug resistance. Moreover, close location of the drug treatment and ART facilities makes its easier to adjust the treatment regimen when administering both methadone and ARV medicines."

708 Ministry of Health, Order "On Substitution Therapy" [О внедрении заместительной терапии], Order No. 609 (8 December 2005).

709 Government of Kazakhstan, Resolution "On Additional Demand for Drug in the Republic of Kazakhstan in 2006", [О дополнительной норме потребности Республики Казахстан в наркотическом средстве на 2006 год] Resolution No. 966 (9 October 2006).

710 The history of the establishment of the OST in Kazakhstan, according to the national expert group, is as follows: On 29 December 2006, Kazakhstan's methadone quota was defined by a government resolution, which was submitted to the International Narcotics Control Board (INCB): Government of Kazakhstan, Resolution No. 1328 "On Amendments to the Governmental Resolution No. 735" (3 August 2006). On 17 October 2007, Government Resolution No. 960, on the Standard Drug, Psychotropic Substances, and Precursors Demands of the Republic of Kazakhstan in 2008, was signed. This resolution specified the methadone quota for 2008. In compliance with Kazakh law, in the case where drugs, psychotropic substances, and precursors are not imported according to the approved state quota by the end of the relevant year, the quota will be considered invalid. Due to the fact that the resolutions on methadone quotas were signed only at the end of 2006, in 2007 the main beneficiary failed to import the medicine since it was necessary to register methadone or to get permission for one-time import, which takes from 6 to 9 months under domestic procedures. As of the end of 2008 health care facilities in the cities of Pavlodar and Temirtau were ready for the project, the methadone had been received under the 2008 quota, and two pilot projects started in November 2008.

711 WHO, UNODC and UNAIDS. Substitution maintenance therapy in the management of opioid dependence and HIV/AIDS prevention: WHO/UNODC/UNAIDS Position Paper. Geneva: WHO, 2004.

Drug user registration
In Kazakhstan, as in other project countries, there is a procedure to register people with drug dependence.[712] People are entered on the registry by a narcologist upon diagnosing mental and behavioural disorders related to drug use. The registry is maintained by the regional narcological dispensaries. Narcologists and nurses registering and making an appointment for a patient have full access to the registry. A person may be removed from the registry after 5 years of being deemed drug-free.

Numbers of registered people are provided to the regional offices of the Statistics and Special Registration Committee under the General Prosecutor's Office. Narcological dispensaries provide statistical information upon request to the Kazakh Prosecutor General's Office.[713] Registration on the drug-user registry entails certain limitations on employment and driving. There is a practice of employers to request narcological certificates before hiring or during work at certain positions (discussed further below in the section on "Discrimination").[714]

As outlined in the box below, in a research survey among injection drug users in 2006, the fear of being registered as a drug user was the single most important factor pushing drug users away from drug dependence treatment and other healthcare services (with consequent implications for undermining HIV prevention and treatment among this vulnerable population as well).

"Demand for treatment of drug dependence":
results of a survey on drug dependence in Kazakhstan (2006)
Between February and April 2006, the Republican Centre for Applied Research on Drug Addiction in Pavlodar, with support from the Regional Office for Central Asia of the UN Office on Drugs and Crime (UNODC), conducted a survey examining certain aspects of drug dependence in Kazakhstan. The respondents were 1200 opioid users in 6 regions of the country. It was found out that 46.4% of the respondents once wanted to obtain treatment but failed. The main reasons were as follows:

- fear of being registered as a drug user (55.5%)
- distrust of state treatment facilities (26.5%)
- lack of money to pay for the treatment (33.8%)
- lack of available space in treatment facilities (27.9%)
- dislike for the therapeutic regimen (27.7%)
- lack of information on possible treatment (16.1%)
- no adequate treatment facility in the region (4.7%)
- dislike for the personnel of treatment facility (4%)
- other reasons (mainly "treatment is not needed") (7.1%).

Drug-related health problems were mentioned by 61.5% of the respondents:

- 32.2% of the respondents knew they had hepatitis B
- 14.3% of the respondents knew they had hepatitis C
- 3.3% of the respondents knew they had HIV
- 8.5% of the respondents had had an STI at some point

Compulsory drug dependence treatment
There are a number of ways under current Kazakh law in which a person can be compelled to undergo treatment for drug dependence.[715]

712 Ministry of Health of the Republic of Kazakhstan, Order "On the Rules of referral, terms of care and assistance to people with drug dependence in medical and social rehabilitation centres (departments)" [Об утверждении Правил направления лиц, больных наркоманией, условиях содержания и объеме помощи больным, страдающим наркоманией, в центрах (отделениях) медико-социальной реабилитации], Order No. 638 (18 August 2004).

713 Law of Kazakhstan "On Prosecutor General's Office" [О прокуратуре], Law No. 2709 (21 December 1995).

714 Order "On the Rules of Drug-dependents' Referral, Care and Extent of Medical Aid in Medical and Social Rehabilitation Centres (departments)", Order No. 638 (18 August 2004), paras. 6 and 9; Government of Kazakhstan, Resolution "On Approval of a List of Medical Psychiatric Contra-indications with Regard to Some Types of Professional Activity and High Risk Works", Resolution No. 668 (18 June 2002), paras. 12.4 and 13; Ministry of Health, "Guidelines on Obligatory and Regular Medical Examination of the Employees Exposed to Harmful, Hazardous, and Unfavorable Factors and Professional Suitability", Order No. 243 (12 March 2004).

715 Compulsory drug treatment is governed by the following instruments: Law "On Compulsory Treatment of Alcohol, Substance, and Drug Abuse", No. 2184 (7 April 1995); Ministry of Health, Order "On Compulsory Treatment Measure, Medical and Social Rehabilitation for Persons Suffering from Mental and Behavioural Disorders as a Result of Using Psychoactive Substances and Avoiding Voluntary Treatment", Order No. 323 (28 July 1995).

First, a person who uses drugs may be ordered to undergo compulsory treatment in a public health care facility by court, based on the initiative of his or her relatives, police, prosecutor, or non-governmental and welfare institutions, if supported by medical diagnosis of drug dependence. Whether or not a person should be ordered into compulsory treatment for drug dependence is considered by a court in a full session, with the participation of the person for whom such treatment may be ordered.

Second, when a person commits an administrative offence that infringes the rights of other individuals or public order, and that person is determined to be suffering from chronic alcohol or drug dependence and is avoiding voluntary treatment, he or she can be ordered by the court to undergo *compulsory treatment* either in a specialized facility for compulsory drug dependence treatment, or units for compulsory treatment in the regular narcological centres, in addition to an administrative penalty. The term of compulsory treatment is defined according to a narcologist's recommendations, but may not exceed two years.[716]

Third, based on the recommendation of a forensic and narcological examination board, people with drug dependence sentenced to imprisonment are subject to that treatment in prisons [717] Kazakh law does not currently provide for 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, 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.[718]

If in general the legislation of Kazakhstan complies with the international standards, provisions on compulsory treatment do not, and are recommended for repeal and the pursuit of alternative approaches instead. For example, as an alternative to imprisoning people with drug dependence who have committed administrative offences or non-violent criminal offences, the experts recommend referral to voluntary treatment in public healthcare facilities. Treatment can be conducted under the supervision of the Ministry of Internal Affairs or the administration of correctional services similar to supervision over persons on parole. People with drug dependence who have committed more serious offences, or who have committed administrative offences but avoided treatment imposed as an alternative punishment, could be sentenced to prison. Additionally, the experts noted that adequate rehabilitation programmes should be organized in the penitentiary system of the Republic of Kazakhstan (on the model of "Atlantis" programme in Kyrgyzstan and Poland) (see section below on "Recommendations for legislative and policy reform").

4B. HIV PREVENTION AND TREATMENT

Kazakhstan's law on AIDS specifies activities aimed at HIV prevention, including access to information on protective measures to prevent HIV transmission and the involvement of non-governmental organizations in this work.[719] It provides also for the development and implementation of specific HIV prevention measures focused on various population groups.[720]

HIV prevention and other health services for people who use drugs
Currently, various harm reduction measures are implemented in Kazakhstan, including awareness-raising and educational activities, needle and syringe exchange programmes. Harm reduction is one priority stated in the National AIDS Programme for 2006-2010,[721] which envisages distribution of quality condoms among vulnerable groups, awareness-raising materials, needle and syringe exchange, confidential and anonymous STI treatment in client-oriented units ('friendly cabinets') under the oblast and city AIDS Centres. Currently, according to the experts, there are 26 'friendly cabinets' in the Republic of Kazakhstan. The Global Fund funds the distribution by AIDS Centres of information on HIV, condoms and sterile syringes.

716 Code of Administrative Offences, Article 59.

717 Law "On Drugs", Article 34.

718 Single Convention on Narcotic Drugs, 1961, 520 UNTS 331, as amended by the 1972 Protocol, Article 36(2); Convention on Psychotropic Substances, 1971, 1019 UNTS 175, Article 22; Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances, 1988, Article 3(4).

719 Law "On prevention and treatment of HIV and AIDS" [О профилактике и лечении ВИЧ-инфекции и СПИД], No. 176-XIII (5 October 1994), Article 2-5, paras. (2) and (4).

720 Ibid., Article 2-5, para. (3).

721 Programme adopted by the Government of Kazakhstan, Resolution No.1216 (15 December 2006).

The national law on AIDS also stipulates the establishment of "trust points" and "anonymous" testing and counselling services, as well as legal and medical consulting. "Trust points" are established to prevent the spread of HIV-infection and other blood-borne diseases among injecting drug users. They are organized as divisions of AIDS Centres and other public health care facilities and are managed by the heads of these facilities.[722] Funding of trust points is provided by the grants of the Global Fund to fight AIDS, tuberculosis and malaria, and by national and regional state budgets. According to the regulations "trust points" should be located in areas with high number of injecting drug users and may also be mobile. They render services free of charge based on the principles of voluntariness, confidentiality, and anonymity, including professional services of dermato-venereologists, narcologists, therapists and TB specialists. "Trust points" are supposed to have a telephone line and occupy at least two rooms, one of which is used for syringe exchange, another for psychosocial counselling and consultations with health care specialists. There is a system of client registration at trust points; confidentiality is ensured through the clients' coding.[723]

People with experience of drug use and people living with HIV are engaged to work in trust points as volunteers (e.g., outreach workers). Volunteers involved in HIV programmes are chosen by the head of organization with which they work; these heads are responsible for training and supervision of volunteers' activity, with the help of the territorial AIDS Centre experts. According to 2006 data, about 70% of persons working as volunteers with trust points were people who have used drugs, ranging from 30% to 100% across different regions. Family members of drug-dependent persons are also engaged as volunteers. Volunteer fees (nominal amounts in recognition of volunteers' efforts) are paid by the Global Fund and in some oblasts by the Government through the Population Employment Centres.

Trust points are authorized to provide the following services:

- distribution of sterile needle and syringes, disinfectants and condoms, as well as gathering used syringes;
- providing information on HIV infection, STI, HIV risk reduction behaviour, HIV testing;
- psychosocial HIV and AIDS counselling and consultations with dermato-venerologists, narcologists, therapists, TB specialists and psychologists;
- referrals for people who use drugs to public hospitals for qualified medical assistance;
- information on organizations providing preventive and other types of assistance to people who use drugs;
- testing for HIV, STIs, and hepatitis B and C; and
- participating in research into risk behaviour patterns among people who inject drugs, to inform the development of HIV risk- reduction measures.

As of January 1, 2008, there were 145 trust points in Kazakhstan. The number of injecting drug users who used the services of trust points during 2007 was 37,310 people, which is 29% of the estimated number of all injecting drug users in Kazakhstan.

Coverage of and barriers to services for people who use drugs

Contact with outreach workers

According to the above-mentioned survey of people who use drugs conducted by Republican Centre for Applied Research on Drug Addiction in Pavlodar-city in collaboration with UNODC's Regional Office for Central Asia, during the last 6 months of 2006, only 12.8% of respondents had contact with outreach workers (at most 2-3 times a week); most respondents (77.7%) had such contact for the purpose of obtaining sterile syringes. Half of those with contact with outreach workers received condoms and information on HIV prevention; 20% received disinfectants, counselling on behavioural changes (including overdose prevention), referral to a trust point and other services.

722 Ministry of Health, Order "On Trust Points" [Об организации деятельности пунктов доверия], No. 228 (9 March 2004), paras. 3, 4.

723 Ibid.

Contact with trust points

Trust points were visited by respondents on average 10.7 times during the preceding 6 months. Most respondents who had had contact with a trust point made contact in order to obtain sterile syringes (82.3% of respondents). Of respondents who had had contact with a trust point:

- two-thirds received HIV information material;
- half received a referral for HIV testing;
- one in three received condoms;
- one in five received testing for hepatitis B and C; and
- one in ten received disinfectant solution, STI testing, education about overdose prevention, referral to drug dependence treatment and consultations with other specialists.

While half (50.2 %) of the respondents knew about the trust point in their district, only 16.4% had visited it. The main reasons respondents gave for not visiting a trust point were:

- fear of being caught by police (30.8%)
- fear of being registered as a drug user (29.1%)
- fear of being noticed by friends (21.9%)
- the inconvenient location of the trust point (12.3%)
- no need for the trust point's services or not knowing about it (21.1%) and
- other reasons (21.1%).

Key conclusions of national expert group regarding access to trust points' services

The national expert group has noted that various factors still create barriers for vulnerable population groups to access to trust points' HIV prevention and health services. These include the following:

- Trust points are mainly established within health care organizations; only 15 trust points (14%) are operating independently from these organizations. According to the situation assessment done by the national expert group, often the target group finds contacts with health care facilities unacceptable. Most of the trust points have no separate rooms, no special personnel to maintain the office throughout the working day and no operation schedule corresponding to the needs of people who inject drugs. For example, a trust point operating within an AIDS Centre may only be open until 4 p.m., not the hours during which people will need to obtain sterile injection equipment. The national expert group has recommended establishing new trust points or relocating existing ones into non-medical institutions (e.g., NGOs).

- In many cities, people who use drugs are afraid to approach trust points because being identified may result in further targeting by police.

- In some cities, in addition to interfering with HIV prevention programmes for sex workers, health services and police still organize raids in the course of which sex workers are subjected to compulsory measures which result in further refusal of many of them to refer to health care services and participate in preventive programmes.

- In different locales, acts of hostility in relation to men who have sex with men (MSM) on the part of both the public and law enforcement bodies were registered, which makes this group even more closed.

- Factors such as those above have impeded coverage of HIV prevention programmes, to an estimated 29% of people who inject drugs and to no more than an estimated 8% of men who have sex with men.

The national expert group has reported that there exists a practice of concluding agreements between law enforcement bodies and organizations rendering services to people who use drugs regarding law-enforcement practices in the vicinity of harm reduction services. Efforts have been made to raise the awareness of local police officers about the goals and objectives of trust points (including syringe distribution or exchange programmes), about not interfering with the operation of trust points, and about the routes of mobile trust points. Similar efforts have been made with officers of the Department of Internal Affairs regarding the HIV prevention

activities of AIDS Centres and organizations doing outreach to sex workers. These activities are included into the joint operational plan of health care facilities and the Department of Internal Affairs. Awareness-raising materials are being issued that specifically target law-enforcement staff, with recommendations not to prevent AIDS Centres personnel and NGO volunteers from HIV prevention work among injection drug users, and HIV prevention issues are included into the training programme for penitentiary and police staff.

Within the framework of the UNODC project, standards of professional competencies comprising knowledge and skills necessary for providing effective HIV prevention for vulnerable groups of population were developed and relevant recommendations for update of curricula of professional under-graduate and post-graduate education were made. Part of these recommendations has been accepted as addenda to the existing state standards in medicine and pharmacy.

Voluntary counselling and testing for HIV

The Law "On prevention and treatment of HIV-infection and AIDS" provides for free, voluntary counselling and testing for HIV that is described both as "anonymous" and "confidential" (with no clear distinction drawn between the two in the law).[724] This law does not explicitly require informed consent for HIV testing, but in 2004 the Ministry of Health issued an order according to which testing is to be conducted with counselling on the condition of informed consent.[725] (Testing of minors and persons lacking decision-making capacity because of disability is conducted based on the consent obtained from their parents or legal representatives.[726]) Counselling is provided by health care professionals and psychologists, including in "trust points" and NGOs. Information about the issues of HIV and AIDS may be provided by peer outreach workers.

Voluntary testing and counselling is carried out in public and private health care facilities licensed to provide this service, including in AIDS and perinatal care centres.[727] In the case of voluntary HIV testing, anonymous testing is possible.[728] In this case, each patient is given a personal code and there is no need for him/her to submit identification documents. According to the national expert group, there are 326 anonymous testing sites and 329 psychosocial counselling sites established within the framework of the National Programme. In the latter sites, the responsibilities of personnel include the following:

- providing pre- and post-test counselling (including discussing the reasons for HIV testing, analyzing the person's risk of HIV infection, and assessing the emotional reaction and possible consequences of receiving the test results);
- referring people to HIV testing based on informed consent; raising awareness about HIV and STI prevention, and the importance of testing for these infections; and
- training people on how to reduce the risks of HIV and STI infection.

According to the national expert group, HIV testing among pregnant women in Kazakhstan has increased considerably due to a new examination procedure and targeted work with obstetrician-gynaecologists on mother-to-child transmission of HIV. Testing is to be conducted on a voluntary basis twice: upon registration of a pregnancy and in the 28th week of pregnancy. All pregnant women are to be provided with pre- and post-test counselling in prenatal centres. Under the National AIDS Programme, funds are allocated for rapid test kits, which are shared between prenatal and obstetrical facilities for testing pregnant women. Women who have not been tested before labour are provided with rapid HIV testing in maternity hospitals.

Access to treatment and care for HIV-infection

Treatment for HIV and tuberculosis is free as these are classified as diseases representing a serious hazard to others.[729] Under Kazakhstan's law on HIV and AIDS, Kazakh citizens with HIV have a right to free pharmacological treatment, outpatient and inpatient care in public health care facilities, and coverage of travel expenses to receive treatment.[730] Pregnant women with HIV and infants born to them are supposed to receive ARV treatment as a strategy for prevention of mother-to-child transmission of HIV.[731]

Before 2008, almost all ARVs were purchased using Global Fund monies, only medication for pregnant women and children was financed from the state budget starting from 2007. As of 2009, all medications are purchased from the state budget. As of 2008, ARV therapy was received by 452 patients out of 742 known patients deemed to be in medical need. According to the National AIDS Programme targets, by 2010 ARV therapy must be received by not less than 70% of patients in need of it. According to the national expert group, injecting drug use by itself should not be an obstacle for prescribing ARVs and cannot be a reason for refusing treatment or exclusion from treatment regimens. People with HIV are treated for drug dependence, tuberculosis, and hepatitis C in specialized health care facilities; transfer from one facility to another is not governed by any specific regulations. Health care for homeless people is carried out in special facilities (shelters) run by police, known as Centres for Temporary Isolation and Adaptation [центры временной изоляции и адаптации]. Health care workers in such shelters must test all admitted people for syphilis, HIV and gonorrhoea.

Mandatory and compulsory HIV testing and/or treatment

Under current Kazakh law, HIV testing and/or treatment may be mandatory or compulsory in a number of circumstances.

Mandatory testing

HIV testing is mandatory for all donors of blood, organs or tissues.[732]

HIV testing is mandatory for all people entering the country for more than 6 months or for permanent residence. Positive HIV diagnosis will not be cause for deportation as long as a foreigner accedes to "preventive observation"; avoiding such observation may lead to deportation.[733] International standards recommend against mandatory HIV testing of foreigners.[734]

As the national expert group has noted, Kazakh law does not currently contain a provision that clearly prohibits employers from making HIV testing mandatory as a condition of employment. According to a joint order of the Ministries of Health and Defence, soldiers must undergo HIV testing upon entering the military and 6 months later.[735] International standards recommend against mandatory testing in the workplace (including military personnel).[736]

Compulsory testing and treatment

Numerous provisions in Kazakh law have the effect of extending very broadly the scope of possible testing without consent and give governmental agencies wide powers in this regard. These provisions raise human rights concerns.

First, prisoners are subject to compulsory HIV testing.[737] People sentenced to imprisonment undergo HIV testing upon admission and six months after admission.[738]

Second, and more broadly, the Law "On Prevention and Treatment of HIV and AIDS" imposes a general obligation on every Kazakh citizen, foreigner or stateless person resident in the country to undergo medical examination at the request of health authorities, the prosecutor's office, or investigative and judicial bodies in cases where there is "sufficient evidence" to think she or he may be infected with HIV.[739] Under

724 Law "On prevention and treatment of HIV and AIDS", Article 5. This article also specifies that prisoners are to undergo compulsory HIV testing.

725 Order of the Ministry of Health of the Republic of Kazakhstan "On the Rules of examination to determine HIV-infection" [Правила об обследовании граждан на выявление заражения вирусом иммунодефицита человека], Order No. 227 (9 March 2004).

726 Ministry of Health, Order No. 648.

727 Ministry of Health, "On the Rules of medical HIV testing" [Об утверждении Правил медицинского освидетельствования на выявление заражения вирусом иммунодефицита человека], Order No. 575 (11 July 2002), and amendments to the above rules, adopted by order of the Ministry of Health of the Republic of Kazakhstan, [О внесении изменений и дополнений в приказ Министра здравоохранения Республики Казахстан от 11 июня 2002 года № 575 «Об утверждении Правил медицинского освидетельствования на выявление заражения вирусом иммунодефицита человека»], Order No. 648 (26 December 2006).

728 Order of the Ministry of Health of the Republic of Kazakhstan No. 575 and Order "On the Rules of examination to determine HIV-infection" [Правила об обследовании граждан на выявление заражения вирусом иммунодефицита человека], Order No. 227 (9 March 2004).

729 Government of Kazakhstan, Resolution No. 468 (30 March 2000), para. 14 (List of socially significant diseases and diseases of serious hazard to others).

730 Law "On Prevention and Treatment of HIV and AIDS" [О профилактике и лечении ВИЧ и СПИД], Law No.176-XIII (5 October 1994), Article 2-4.

731 Ibid.

732 Law "On Prevention and Treatment of HIV and AIDS", Article 5; Ministry of Health, "On the Rules of medical HIV testing", Order No.575 (11 June 2002).

733 Ministry of Health, Order "On HIV Prevention in the Republic of Kazakhstan", Order No.10 (19 February 2007).

734 UNAIDS/IOM Statement on HIV/AIDS-related travel restrictions (2004).

735 Joint Order of the Ministry of Health No. 562 (4 November 2005) and the Ministry of Defence No. 342 (19 September 2005).

736 UNAIDS/OHCHR, International Guidelines on HIV/AIDS and Human Rights (2006 Consolidated Version), Guideline 5 ("Anti-discrimination and protective laws"), para. 22(a), (d), (j).

737 Law "On Prevention and Treatment of HIV and AIDS", Article 5.

738 Ministry of Health, Order "Amending the Order of the Ministry of Health "On the Rules of medical HIV testing", No 575 (11 July 2002)", Order No. 648 (26 December 2006) [Приказ Министра здравоохранения от 26 декабря 2006 года № 648 О внесении изменений и дополнений в приказ Министра здравоохранения Республики Казахстан от 11 июня 2002 года № 575 «Об утверждении Правил медицинского освидетельствования на выявление заражения вирусом иммунодефицита человека»].

739 Law "On Prevention and Treatment of HIV and AIDS", Article 6, para. 1.

this law, authorized law enforcement bodies may subject people to compulsory HIV testing. The results of such examination are made available only to the body that has sent the person for compulsory testing, and cannot be made available to other agencies. The testing is conducted in AIDS centres.[740]

Third, the Law "On Health Protection" also provides for examination, treatment, and medical intervention without consent in the following cases, among others:

- persons with diseases that pose a "serious hazard" to others; and
- persons suffering from mental disorders who have committed "socially dangerous acts" (i.e. administrative or criminal offence).[741]

Under this law, compulsory testing and treatment of all people with HIV is possible because, as already noted above, HIV, viral hepatitis and tuberculosis are all classified as diseases representing a "serious hazard" to others.[742] Furthermore, the *Code of Administrative Offences* imposes administrative liability, punishable by fines, for avoiding medical examination or treatment in the case of a person with a disease which can be a "serious hazard" to others.[743]

Patients' rights, including confidentiality

Basic patients' rights are specified in the Kazakh Constitution, which stipulates that citizens have a right to health protection. The Law "On Health Protection" lists patients' rights to medical treatment, to appeal actions (or the failure to act) of medical staff and health agency officials and to refuse medical treatment.[744] According to Article 15 of the Law "On Public Health Care" people can complain on actions/inaction of public health staff and health care institutions to the supervising healthcare authority or to courts. According to the experts, complaints related to the quality of medical service and inhuman and degrading treatment are reviewed by the Committee on Medical Service Quality Control under the Ministry of Health.[745]

As a general rule, diagnostic and treatment information of people living with HIV is confidential and may be revealed only to the patient or the patient's legal representative. The HIV law requires medical staff and others who, as a result of their profession, are privy to information about a person's HIV status to keep this information confidential.[746] The *Penal Code* imposes criminal liability for disclosing medical secrets.[747] However, this confidentiality is subject to some very significant exceptions: for example, a patient's health information must also be disclosed at the request of health care authorities, a prosecutor's office, investigative bodies and a court.[748]

With respect to the obligation to undergo examination, and possible administrative liability and punishment for avoiding it, the national expert group has recalled in its report that health care facilities are instructed to apply universal precautions to protect against infection with blood-borne diseases such as HIV. There are concerns that a legal obligation to disclose HIV-positive status to medical personnel when seeking care, and the possibility of legal liability and punishment for not disclosing, will make some patients afraid to seek health care services because of a fear of being refused care once known to be HIV-positive. It is recommended that such a legal requirement of disclosure should be abolished.

740 Law "On Prevention and Treatment of HIV and AIDS"; "On the Rules of medical HIV testing", Order No.575.

741 Law "On Health Protection" [Об охране здоровья граждан], Article 17.

742 Government of Kazakhstan, Resolution No. 468 (30 March 2000), para. 14 (List of socially significant diseases and diseases of serious hazard to others). There is also a general legal obligation of individuals to maintain their health, and also specifically obliges people with diseases that pose a hazard to others to follow the orders of medical professionals and health care authorities and facilities, to inform medical personnel about their disease when seeking care and to follow treatment prescribed by medical professionals and health authorities: Law "On Health Protection", Articles 18-19.

743 Code of Administrative Offences, Articles 326-327. In addition, the Code makes it an administrative offence to conceal the source of such an infection (if known) and the names of persons with whom they have had context (e.g., past sexual partners): Article 328.

744 Law "On Health Protection", Articles 14-16.

745 In practice, however, the national expert group reports that there is a lack of a working mechanism of bringing the infringer to responsibility and a low level of consciousness of medical personnel when infringing the patients' rights. According to the expert group, these facts are usually covered in mass media, but no measures are taken to eliminate them and hold those responsible legally accountable.

746 Law "On Prevention and Treatment of HIV and AIDS", Article 11.

747 Penal Code of the Republic of Kazakhstan, [Уголовно-исполнительный кодекс Республики Казахстан], No. 208-1 (13 December 1997, Article 144. This Article provides for a special provision and stricter punishment for breaching confidentiality with respect to HIV. Part 1 of the Article specifies a fine or corrective labor for a term less than one year in the case of a medical worker disclosing any information on a patient's disease or medical examination results without professional need. Part 2 deals specifically with such a breach that discloses a person's HIV-positive status; it specifies a stricter fine, or corrective labour for a term less than 2 years, or deprivation of a right to hold particular positions for a period from 2 to 5 years.

748 Law "On Health Protection" [Об охране здоровья граждан], Article 29.

5. PRISONS

Kazakhstan's correctional system

In Kazakhstan, the penitentiary system falls under the Ministry of Justice. Pre-trial detention is used extensively, in particular with respect to drug-related crimes (most commonly drug trafficking and violent offences).

As of August 1, 2007 there were 75 correctional institutions in Kazakhstan. The degree of security of the institution to which a person is sentenced will depend on the gravity of the offence. According to the national expert group, most people convicted of drug-related crimes serve their sentences in maximum security penal establishments.

Juvenile offenders serve their sentences in juvenile correctional facilities, with "regular", "minimum", "preferential", and "strict" security. Juvenile offenders may be ordered to undergo compulsory treatment in the correctional facility following court order. Medical treatment of drug-dependent persons in juvenile correctional facilities is to be carried out mandatorily alongside labour activities and general school education. (Legislation does not stipulate any differentiation in incarceration conditions for juvenile prisoners with HIV.)

> The organization and monitoring of medical care services in the penitentiary is carried out by medical units of the penitentiary, which is also under the Ministry of Justice. Prisoners with HIV and AIDS are treated by AIDS centres specialists.

According to the Law "*On Judicial Authorities*", the correctional system includes rehabilitation centres, whose key function is rendering assistance in employment and lodging, and legal and psychological aid, to prisoners for six months following release.[749] Currently, special regional supervisory committees have developed draft orders on establishing rehabilitation centres in two regions of Kazakhstan. For the sake of accountability and the observance of human rights, special regional public supervisory boards are established for prisons, with the authority to:

- attend penal institutions and detention facilities without hindrance by authorities;
- talk to prisoners, with their consent, and accept complaints regarding violation of their rights and legitimate interests; and
- file applications with the administration of penal institutions, detention facilities, and the prosecutor's office to ensure respect for the rights and legitimate interests of persons in correctional institutions and detention facilities.

Basing on their findings, members of the public supervisory boards are entitled to send proposals for improvement of an institution's operation to the institution's administration.

HIV prevalence and risk behaviours in prisons

As of 2003, the National AIDS Centre has been conducting sentinel epidemiological surveillance in correctional institutions. In recent years, the prevalence of HIV, hepatitis C and syphilis in pilot penal establishments has been estimated as follows:[750]

Year	HIV	Syphilis	Hepatitis C
2003	0.2% - 1%	0.7% - 1.8%	32.4% - 37.2%
2004	0.8% - 2%	8.0% - 11%	32.3% - 37.1%
2005	0.4% - 1.5%	7.5% - 15.3%	23.5% - 53.4%
2007	2%	12%	43%

749 Law "On Judicial Authorities" [Об органах юстиции], Law No. 304-2 (18 March 2002), Article 11.

750 Information provided by the national expert group.

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.[751] In 2006, within penal system establishments, 115 prisoners with HIV started treatment, but in 2007 only 63 people were still continuing treatment, representing an adherence rate of only 55%.[752]

According to the national expert group, it is recognized that risk behaviours such as injecting drug use and unprotected sex between prisoners take place; other risk factors are tattooing and the sharing of shaving accessories. In a survey of prisoners conducted in 2006:

- 44% of prisoners agreed that injecting drugs are used in penitentiary system;
- 24% of them said that several prisoners share syringes;
- 12,9% asserted that prisoners use other means at hand for injecting drugs; and
- only 12% of the respondents confirmed that drug injecting equipment was treated with disinfectant solutions before use.[753]

In the same survey, 40% of respondent prisoners confirmed that prisoners have sexual relations with other prisoners, with condom use "less than in half of cases". In addition, based on responses, the researchers characterized roughly one-third of prisoners in the country as generally ill-informed about the basics of HIV transmission.

According to the information provided by the national expert group, until 2001, the attitude of the Kazakh penal system toward people with HIV was repressive, reflected in measures such as complete isolation of HIV-positive prisoners and frequent compulsory HIV testing. Following the government's adoption of a "National Concept" on HIV in 2000 (noted above), the attitude to HIV in Kazakhstan has changed. Legislation and regulations dealing with HIV in the penal system[754] have been liberalized, there is greater protection for peoples' rights and better conditions for HIV prevention in prisons have been created.

Programmes and strategies

The main objectives of Kazakhstan's *Programme for Countermeasures to AIDS and HIV Epidemics in the Penal System for 2007-2010* [755] are: stabilization of HIV epidemics in prisons (prevention)[756] and provision of medical care which will result in improvement of the quality of life of people living with HIV and will reduce mortality to the level of the general population.

The objectives set forth in the Programme are implemented through the following strategies:

- interdiction of drug supply in prisons;
- abstinence-oriented drug dependence treatment;
- reduction of drug demand in prisons, development of "anti-drug resilience", reduction of harms associated with injecting drug use (HIV prevention);
- prevention of sexual transmission of HIV through condom promotion and dissemination, and treatment of sexually-transmitted infections;

751 Sentinel Epidemiological Surveillance Report (2007), National AIDS Centre.

752 The national expert group suggests several reasons that could explain such low adherence, including: side effects related to hepatotoxic ARV medications that occur with patients suffering from concomitant hepatitis C when ARV treatment options are limited and hence switching regimens to less toxic ARVs is not an option; limited skills of medical staff in treating patients with ARVs; unclear distribution of duties between the penal system establishments' medical units and regional AIDS Centres in the area of providing ARV therapy and hence inadequate coordination to ensure continuity of medical treatment; and an unproven system of monitoring and evaluating ARV therapy.

753 Information provided by the experts, citing Sentinel Epidemiological Surveillance Report (2006), National AIDS Centre.

754 E.g., Penal Code of Kazakhstan, [Уголовно-исполнительный кодекс Казахстана], No. 208-1 (13 December 1997), Article 97 (requiring the segregation of HIV-positive prisoners); Joint Order of the Ministry of Justice No. 140 (6 December 2001) and the Ministry of Health No. 1122 (10 December 2001) and the Ministry of Internal Affairs No. 862 (7 December 2001) "On HIV/AIDS Prevention among prisoners of the Republic of Kazakhstan Ministry of the Interior and Ministry of Justice"[О мерах по предупреждению распространения ВИЧ/СПИДа среди прикрепленного контингента МВД и Министерства юстиции Республики Казахстан], (stipulating compulsory HIV testing and regulating HIV activities in the framework of the penal system).

755 Programme for Countermeasures to AIDS and HIV Epidemics in the Penal System for 2007-2010 [Программа по противодействию эпидемии ВИЧ и СПИД в учреждениях УИС в Республике Казахстан на 2007-2010], Order of the Ministry of Justice of the Republic of Kazakhstan, No. 229 (14 August 2007).

756 HIV incidence among people who are HIV-negative at the moment of admission to prison should not exceed 1:1000 after 12 months.

- prevention of mother-to-child transmission of HIV;
- providing access to post-exposure prophylaxis;
- prevention of diseases associated with HIV;
- prevention of hospital-acquired (nosocomial) HIV transmission;
- rendering of antiretroviral treatment;
- treatment of opportunistic infections, palliative therapy, rendering care and support to people with HIV;
- creation of legal and social environment conducive to effective implementation of preventive and therapeutic interventions; and
- improvement of epidemiological surveillance, monitoring, and evaluation.

New preventive interventions identified in the 2007-2010 programme are: prevention of mother-to-child HIV transmission and provision of ARV therapy in prisons. For the first time, prisoners at risk of HIV will obtain access to hepatitis B immunization, and persons living with HIV will be provided with chemical prophylaxis of tuberculosis.

Besides the Programme for Countermeasures to HIV and AIDS Epidemics in the Penal System, *the Programme of the Development of the Penal System of Kazakhstan for 2007-2009*[757] provides for introduction of a range of measures on the improvement of infrastructure of penal institutions, hospitals and treatment facilities, in particular, the provision of medical equipment for early detection and treatment of infectious and other diseases in correctional and detention facilities.

Treatment for drug dependence

According to the Penal Code of Kazakhstan, health care facilities are established in the penitentiary in order to provide prisoners with health care services (health units, hospitals, and special psychiatric and TB hospitals). Currently there are no special medical correctional facilities for prisoners with drug dependence.[758]

According to the information presented by the experts, voluntary drug treatment is provided in prisons. If a prisoner, who is not subject to compulsory treatment, appears to be dependent on drugs, he/she is offered to undergo a voluntary course of therapeutic treatment. In case he/she refuses voluntary treatment, the medical board may request the prison administration to address the court to obtain order for compulsory drug dependence treatment.

Compulsory drug and alcohol dependence treatment of prisoners is provided in the medical unit of the correctional facility by a psychiatrist-narcologist, medical practitioner or the head of the medical unit. Prisoners undergoing drug dependence treatment are registered. According to standards, drug dependence treatment should not be interrupted — after detoxification (assisted by medication), relapse prevention therapy should be prescribed. Prisoners who interrupt their treatment are subject to treatment of the relapse.

If there is no relapse and interruption in the course of treatment (completion of treatment course), the medical board prepares materials for an application to the court by the prison administration for a decision on termination of compulsory treatment. If treatment is not finished by the time a prisoner is released, the medical board may request that it be continued. Based upon such a conclusion by the medical board, the prison administration may request from the court an order that the person continue compulsory treatment in a health care facility outside prison. In all cases of release of prisoners undergoing compulsory drug treatment from prison, one month before his/her release, the medical unit sends health care authorities in the place of a released person's permanent residence an extract from his/her medical record on the treatment conducted and its results.

HIV prevention

Some HIV prevention services are provided in the penitentiary system of Kazakhstan: (a) distribution of informational materials about HIV and its prevention; (b) condoms distribution; (c) availability of disinfect-

757 Programme of the Development of the Penal System of Kazakhstan for 2007-2009 [Программа дальнейшего развития уголовно-исполнительной системы Республики Казахстан на 2007-2009 годы].

758 Penal Code of Kazakhstan, Article 97(2).

ants. Such measures as OST and needle and syringe exchange programmes for people who use drugs are not carried out in Kazakh prisons.

Condoms and chlorine-containing sterilizing agents are freely available in the unit's common areas and in rooms used for conjugal visits.[759] However, internal prison regulations prohibit possession of sharp and piercing objects, including needles and syringes.[760]

Since 2002, peer-to-peer awareness-raising and educational programmes have been implemented in pre-trial detention and prison facilities, with peer consultants being trained in medical units of prisons. Apart from this, regional AIDS Centres together with NGOs organize round tables and workshops on the topic of HIV prevention. According to the national experts, as a result of this measures HIV awareness of prisoners has improved, availability of HIV protective materials has considerably increased. In 2005 and 2006, 60% of the prisoners showed good awareness of HIV; 80% of respondents in 2005 and 89% in 2006 stated that sterilizing agents are available in prisons; and 66% of respondents in 2005 and 88% of respondents in 2006 stated that condoms are available in prisons.[761]

Laundry and toilet soap is distributed free of charge. Disposable safety razors are available to prisoners for purchase in the prison shops and can be sent in parcels received from outside. Prisoners with certain health conditions (including HIV and hepatitis) can receive additional parcels and packages as defined in a medical resolution.[762]

HIV testing and treatment in prisons

There is a contradiction in Kazakh legislation on HIV testing of prisoners: according to the Law "On Prevention and Treatment of HIV and AIDS" HIV testing of prisoners is mandatory,[763] yet according to the Order of the Ministry of Health and the Ministry of Justice HIV testing of prisoners is conducted *voluntary*.[764]

Upon admission, every prisoner must undergo confidential HIV testing, together with counselling about HIV, including information on risks of HIV transmission and protection measures. If a prisoner refuses to receive the results of testing, they are not provided and not registered in medical documentation.[765] Information related to diagnostics, treatment, laboratory test results are confidential and must be provided only to the person concerned or his/her representative; however, major exceptions to confidentiality exist, such that this information may be provided to health care bodies, the prosecutor's office, investigative and court bodies by request.

As noted above, prisoners with HIV are provided with antiretroviral treatment in penal system establishments. When persons with HIV are released from prison, information on these persons' arrival is sent to the National and regional AIDS Centres for their registration and follow-up to ensure continuity of HIV treatment which was started in a prison.[766]

Transfer and release of prisoners

After serving a certain part of the sentence, a prisoner deemed to have shown good behaviour may be transferred to less strict penal establishment. However, persons who have not completed compulsory drug dependence treatment and need special treatment in custodial medical institutions are not subjected to transfer to facilities with less strict regime.[767] Prisoners who have not completed compulsory treatment cannot be granted a short term leave from the penitentiary.[768]

Kazakhstan's criminal legislation allows for substitution of part of the prison term with lighter punishment, suspension of a sentence, or lifting of a sentence, on account of illness. The *Penal Code* gives a precise list of cases of early release, such as disability or disease of a prisoner, pursuant to the list of diseases that are ground for release, which includes an AIDS diagnosis with explicit clinical manifestations.[769]

759 The Departmental Programme on HIV/AIDS Countermeasures in the Institutions of Criminal-Executive System of the Ministry of Justice of the Republic of Kazakhstan for 2007-2010 adopted by the Order of the Ministry of Justice No. 229 (14 August 2007); and Budget of the "Programme on AIDS Countermeasures in Correction and Detention facilities".

760 List of items, products, substances, documents, and food products forbidden to sell and use by the prisoners, Appendix to the Rules of the Internal Order in Correction Facilities, Ministry of Justice No. 148 (11 December 2001).

761 Sentinel epidemiological surveillances in 2005 and 2006 covered 4770 and 4486 prisoners, respectively, serving their sentence in correctional facilities of the Republic of Kazakhstan. This information is provided by the national experts of the Republic of Kazakhstan.

762 Government Resolution dated September 2, 2003 No. 889 "On the Rules of Free Food for Suspected, Accused, Including Pregnant Women and Women with Children, Disabled Persons of I and II Groups of Disability, Juveniles, Food Standards and Material Everyday Provision for Prisoners" and Penal Code, Article 85.

763 Law "On Prevention and Treatment of HIV and AIDS", Article 5.

764 Joint Order of the Ministry of Justice No. 96 (28 March 2005) and the Ministry of Health No. 179 (13 April 2005), "On HIV Prevention Improvement in Institutions of Penitentiary System of the Ministry of Justice of the Republic of Kazakhstan" [О мерах по совершенствованию профилактики ВИЧ инфекции в учреждениях уголовно-исполнительной системы Министерства Юстиции Республики Казахстан], para 2(1).

765 Ibid.

766 Prisoners' HIV Prevention, Diagnostics, and Treatment Plan for 2007-2009, para. 11.

767 Penal Code, Article 73

768 Penal Code, Article 93.

769 Penal Code of Kazakhstan, Article 168. The List is approved by the Order of the Criminal Executive System Committee Chairman, Ministry of Justice, Order No. 47-ОД (22 May 2007); also Instruction on Medical Examination and Recommendation for Remission of Sentence due to Disease approved by the Order of the Ministry of Justice of the Republic of Kazakhstan, No. 152 (11 December 2001).

6. DISCRIMINATION AND RESTRICTION OF RIGHTS

The following legal instruments in Kazakhstan address forms of discrimination of particular relevance to responding effectively to HIV:

- Article 14(2) of the Constitution asserts that "no person is to be subjected to any type of discrimination based on the origin, social, official or property status, sex, race, ethnic origin, language, religion, beliefs, domicile or any other ground".

- The Kazakh Government's resolution on measures to address AIDS contains a provision on strengthening support of constitutional rights and freedoms of citizens and the social protection of particular population groups vulnerable to HIV.[770]

- The Law "On Prevention and Treatment of HIV and AIDS" prohibits discrimination based on HIV-positive status.[771] In particular, it contains provisions prohibiting termination of employment or refusing to employ a person, denial of enrolment in preschool and educational institutions, and impairment of other rights and legitimate interests of persons living with HIV or AIDS, including housing and other rights of their family and relatives.[772]

- According to the *Criminal Code*, direct or indirect restriction of rights and freedoms of an individual based on origin, social status, official capacity, property status, gender, race, nationality, religion, beliefs, place of residence, membership in public associations or "under any other circumstances" is recognized as violation of the equality.[773] Such discrimination is punishable by a fine, arrest for up to three months or imprisonment for up to one year. A criminal act of discrimination committed by a person abusing his or her official status is punished with a higher fine, arrest for the period of up to six months or imprisonment for up to two years with deprivation of right to hold specific posts or prohibition to be engaged in specified activity for up to three years.

The national expert group has reported that, despite the legal prohibitions of discrimination (including a clear prohibition of discrimination against people with HIV), there is still certainly discrimination against vulnerable groups, and note the following:

- In practice, discrimination cases are not generally tried in court.
- Vulnerable groups manifest a lack of trust in authorities, such as fear of health professionals and law enforcement officers.
- Widespread intolerance persists in society toward people with HIV and vulnerable population groups. For example, statements made in mass media are often incorrect and overtly discriminatory toward vulnerable groups, contributing to their stigmatization and marginalization.

According to the analyses provided by the national experts, current HIV-related legislation is still contradictory. On the one hand, the law protects people with HIV; on the other, it imposes restrictions on people with HIV that are unrelated to HIV prevention and are unfounded on public health grounds, and that manifest and encourage HIV-related stigma.

Persons using drugs and those registered in drug treatment facilities are subject to legal restrictions that, in their current formulation, are discriminatory, including the following:
- denial of a driver's license;[774]
- prohibition on holding certain kinds of employment (e.g., in pharmacological facilities, in certain safety-sensitive positions);[775] and
- prohibition on adoption.[776]

In addition, provisions of the Law "On Marriage and Family" allow to interpret them in such a way that a parent may be deprived of parental rights if he or she is merely "recognized in due order as a person abusing alcohol, drugs or substances."[777]

There are contradictions between the cited Ministry of Health policy and broader government policy on the issue of prohibition of employment to certain jobs of people who previously used drugs: the Ministry of Health order provides that such employment restrictions do not depend on the current state of person's health (i.e. even if a drug dependent person is in the state of remission he/she still cannot be employed for certain jobs), but the Government resolution states that for the person in remission restrictions on many types of activities and driving are lifted.[778] It is recommended to review current regulatory acts in order to ensure no unjustified discrimination in employment based on drug use.

Similarly, although the national AIDS law prohibits discrimination in the form of refusing to an employ a person based on HIV status, as has been noted above (in Section 4) there is no clear legal prohibition on mandatory HIV testing in the employment context, which is itself a form of HIV-based discrimination. In addition, at least one of category of workers (i.e., military personnel) is subject to mandatory HIV testing as a condition of employment. Legislative reform to address this sort of HIV-based discrimination is needed.

Finally, while clearly the law must be concerned with protecting the best interests of children, it is of concern if this provision amounts to depriving people of all parental rights simply on the basis of drug use or dependence. Drug use or dependence should not be assumed to be *per se* a justifiable basis for removing children from parental custody in cases where there is concern about child abuse or neglect. Fear of losing children under such a provision may be a barrier to people seeking health services for assistance with drug use or dependence. In addition, it would be incorrect and unfairly discriminatory to equate automatically drug use or dependence with inability to parenting or to assume that depriving a parent and child of that relationship is necessary or necessarily in a child's best interests. As with all cases, a case-by-case assessment, taking into account all the circumstances of a given case, is what is required as good practice and as a matter of fairness.

770 Government Resolution "On State Policy Concept of Countermeasures to AIDS Epidemic in the Republic of Kazakhstan", para. 3.1, part 3.

771 Law "On Prevention and Treatment of HIV and AIDS", Article 2-4(4).

772 Law "On Prevention and Treatment of HIV and AIDS", Article 2-4 (4) and Article 7.

773 Criminal Code, Article 141 ("Violation of Citizens' Equality").

774 Ministry of Health, "Guidelines on Obligatory Preliminary and Regular Medical Examination of Workers Exposed to Harmful, Dangerous, and Unfavorable Production Factors and Professional Fitness Procedure", Order No. 243 (12 March 2004), para. 13.2.

775 Ibid., para. 12.4; and see Government of Kazakhstan, Resolution "On Approval of a List of Medical Psychiatric Contra-Indications for Certain Professional Activities and High-Risk Works", Resolution No. 668 (18 June 2002).

776 Resolution No. 482 (24 June 1999) ("List of Diseases Preventing from Child Adoption, Guardianship (Patronage), and Foster Care), para. 3.

777 Law "On Marriage and Family", No. 321-I (17 December 1998), Article 67, para. 5.

778 Ministry of Heath, Order No. 243; Government of Kazakhstan, Resolution No. 668.

7. RECOMMENDATIONS FOR LEGISLATIVE AND POLICY REFORM

In reviewing legislation and policy affecting HIV prevention and treatment for injection drug users and within the penal system, the national expert group identified a number of over-arching observations and areas of concern requiring attention.

First, the experts noted the necessity of further improving the current HIV/AIDS legislation. According to the expert group, legislative restriction of rights of people living with HIV and AIDS is not necessary from the point of view of HIV prevention, and is unjustified from the public health perspective. Limitations of rights of people living with HIV leads to stigma and further spread of HIV epidemic.

Second, current approaches create numerous barriers to responding effectively to the health problem of drug dependence and to related health problems among people who use drugs, such as HIV. In particular, the expert group noted the following:

- Under current legislation, people who cannot overcome dependence on drugs, lacking legal access to those drugs, must purchase them illegally and are therefore defined as criminals. As a result, people who use drugs are motivated to avoid HIV prevention programmes and other health services; seeking out services can mean being identified as a drug user, thereby risking arrest by police and criminal prosecution and punishment.

- In addition, treatment offered in narcological dispensaries is not necessarily well-suited to accommodate people who use drugs (both HIV-negative and HIV-positive). The only treatment offered is abstinence-oriented, even though the effectiveness of this single approach is very limited. As a result, people who inject drugs are not motivated to have contact with medical or other authorities and refuse to participate in preventive projects. Furthermore, both confidential and anonymous treatment is often fee-for-service only; many of those most in need of treatment are indigent. While there are some well-equipped medical facilities (e.g., the Republican Academic and Research Centre of Medical and Social Drug-related Problems in Pavlodar), such facilities cannot address the full scope of the need for treatment and rehabilitation across the country.

Third, despite NGOs' important contribution to HIV prevention efforts, including prevention among the most vulnerable population groups, their activities are not regulated, which often makes it difficult for NGOs to work with target groups, and to interact with the government sector. Funding and procedures for government contracts for NGO assistance should be developed in Kazakhstan.

Fourth, in Kazakhstan the access of target population groups to STI treatment is still low. Services are mainly connected with attending dermato-venereologic dispensaries, which are fee-based. In order to obtain free medical care, one needs to be registered in an STI treatment facility and provide information on one's contacts under threat of administrative sanctions provided for by the *Code of Administrative Offences*. Inpatient treatment is required in the case of an STI diagnosis such as syphilis. Such obstacles often cannot be overcome by vulnerable groups of population and youth, and are not required by international STI treatment protocols supported by the WHO. According to the national experts, the contradiction between public needs and the way how STI treatment is organized in the country lead to the fact that rates of STI are high among the population, which creates a favourable environment for HIV transmission. There is no national policy on providing youth and vulnerable population groups with quality condoms, which are expensive.

Fifth, the response to HIV prevention in prisons needs to be strengthened in several ways.

- More efforts should be made to work with prisoners as peer HIV prevention educators within prisons.
- Considering the fact that opioid use is a principal driver in spreading HIV among prisoners, the national expert group concluded that implementation of opioid substitution therapy in prisons should be thoroughly considered. This intervention is recommended by the WHO, UNODC and UNAIDS.[779]
- Similarly, the national expert group concluded that it is necessary to consider introducing such interventions in the penal system of Kazakhstan as sterile syringe programmes, which are recommended by the WHO and reflect international best practice. The AIDS Programme in Kazakhstan for 2006-2010 recognizes the value of needle and syringe programmes among injection drug users outside prisons. Kazakhstan should respect the principle of providing prisoners with the same HIV prevention and treatment services as are available outside prisons; implementing needle and syringe programmes within prisons is also in compliance with Kazakhstan's obligation to take measures to protect and promote the highest attainable standard of health for all persons (including prisoners), as stipulated in the *International Covenant on Economic, Social, and Cultural Rights* (Article 12), which it has ratified.

Sixth, efforts to improve access to antiretroviral treatment are needed. Access to ARV treatment improves the health and prolongs the lives of people living with HIV, including their capacity for employment; such benefits are a strong motivation for people to seek testing to learn their HIV status. ARV treatment further supports HIV prevention by reducing viral load and therefore lowering the risk of HIV transmission to others (e.g., sexual partners).

In addition to these over-arching observations, the national expert group put forward a number of specific recommendations. These have been incorporated into the recommendations below, and supplemented with additional recommendations from the project's technical advisors — including, in many instances, suggestions for specific legislative amendments that could be made to implement those recommendations. Suggested language of legislative amendments is highlighted.[780] See also the Annex to this country report, listing specific detailed amendments to existing Kazakh laws and regulations, as prepared by the national expert group.

National programmes and strategies

Recommendation 1: Support involvement of civil society and affected groups

The national expert group has recommended that there be a clear legal regulation supporting the activities of outreach workers and peer educators, including those involved in operating needle and syringe programmes. In addition, a regulation should be adopted that supports the involvement of NGOs, people living with HIV and people who use drugs in elaborating and implementing national programmes and strategies on HIV and on drugs.[781]

Recommendation 2: Strengthen harm reduction strategy and efforts

The national expert group has recommended a number of steps be taken to strengthen harm reduction efforts, such as the following:

- A full harm reduction strategy should be developed by the responsible governmental agencies and adopted by the Government, including harm reduction measures in penal institutions, with the objective of preventing HIV and protecting and promoting the health of people who use drugs.

- The Ministry of the Interior and the Ministry of Health should develop guidelines on interaction between public bodies (especially law enforcement bodies) and centres implementing harm reduction programmes, within the framework of the Programme on Combating Drug Dependence and Drug Trafficking.

779 Joint Position of WHO/UNDP/UNAIDS on Substitution Maintenance Therapy among Opioid-Dependent Patients and HIV Prevention, Geneva, 2004.

780 In many instances, the wording of proposed legislative amendments is adapted from model provisions in Legislating for Health and Human Rights: Model Law on Drug Use and HIV/AIDS (Toronto: Canadian HIV/AIDS Legal Network, 2006), online in both English (www.aidslaw.ca/modellaw) and Russian (www.aidslaw.ca/modellaw-ru). This publication, consisting of a series of 8 modules on different issues, was used as a key reference by UNODC, national expert groups and the project's technical advisors during the review and assessment of national legislation in the countries participating in the project. Where relevant, citations below are to specific modules of that resource; the accompanying text and commentary to be found in those modules may be useful to legislators and policy-makers in implementing these recommendations.

781 The national expert group has explicitly recommended that such regulations be developed with reference to the model provisions found in Legislating for Health and Human Rights: Model Law on Drug Use and HIV/AIDS, Module 6: Outreach and Information (Canadian HIV/AIDS Legal Network, 2006).

Recommendation 3: Reduce penalties for offences involving drugs where no intent to sell, and depenalize possession for personal use entirely

As noted above, *even when there is no intention to sell drugs*,

- the *Code of Administrative Offences* (Article 320) imposes administrative liability for various drug offences (including possession) involving "small" quantities; and
- the *Criminal Code* (Articles 259.1 and 259.1-1) imposes serious criminal liability for various drug offences (including possession) involving "large" quantities (up to 3 years' imprisonment) and "extra large" quantities (up to 7 years' imprisonment).

Given the nature of drug dependence as a chronic, relapsing condition, such provisions largely have the effect of penalizing people with the health condition of drug dependence. Indeed, this is particularly evident in the Republic of Kazakhstan, given that the thresholds for defining quantities of drugs as "small" (e.g., <0.01g of heroin), "large" (e.g., 0.01-1g of heroin) and "extra large" (e.g., > 1g of heroin) are very low in the schedules under the Law "On Drugs" — in fact, Kazakhstan's schedules are among the strictest in Central Asia. The Government of Kazakhstan should consider (1) reducing the extent to which administrative and criminal penalties are used to respond to drug offences that involve only personal use, and (2) should consider removing entirely any penalties, whether administrative or criminal, for *possession* of quantities for personal use.[782] This could be done with legislative action such as both of the following:

- Amend the schedules under the Law "On Drugs" to increase the minimum threshold for defining what constitutes a "small" and a "large" quantity of drugs. Such amendments should reflect the reality of the quantities used regularly by people with drug dependence.[783]

- Insert a provision such as the following into the *Criminal Code* and *Code of Administrative Offences* to fully decriminalize and depenalize *possession* without intention to sell (i.e., for personal use):

> Notwithstanding anything in the *Criminal Code of the Republic of Kazakhstan* or the *Code of the Republic of Kazakhstan of Administrative Offences*, the use and possession of a controlled substance in a small quantity attracts neither an administrative nor a criminal penalty.

Recommendation 4: Supporting effective operation of needle and syringe programmes

The national expert group recommended changing the hours of operation and other procedures of the existing trust points (in AIDS centres and other public health facilities), in order to make them more accessible for people who use drugs.

In addition, with the objective of supporting effective HIV prevention among injection drug users and protecting the public health more generally, the national expert group has recommended creating a clear legislative framework for needle and syringe programmes, including the disposal of used syringes. Such a framework should also support the effective operation of such programmes by ensuring clear legislative support for the work of outreach workers, including 'peer' workers (i.e., people who use or have used drugs, or other members of the affected population who is to be reached with these health services). Wording of legislative provisions such as the following could be introduced to the existing *Law on Prevention and Treatment of HIV and AIDS* or other suitable legislation:[784]

782 See Legislating for Health and Human Rights: Model Law on Drug Use and HIV/AIDS, Module 1: Criminal law issues, pp. 18-21.

783 The schedules in effect in Tajikistan offer one regional example of an approach that is significantly less strict in defining the various ranges of drug quantities for legal purposes.

784 See Legislating for Health and Human Rights: Model Law on Drug Use and HIV/AIDS, Module 3: Sterile syringe programs, pp. 12-15.

Sterile syringe programmes

(1) "Sterile syringe programme" means a programme that provides access to sterile syringes and other related material, information on HIV transmission and other blood-borne pathogens, or referrals to substance abuse treatment services. It includes needle exchange programmes, needle distribution programmes and other forms of sterile syringe distribution.

(2) Staff of the sterile syringe programme may provide a range of material and services, including the following:
a) sterile syringes and other related material for safer injection drug use, including sterile water ampoules, swabs, filters, safe acid preparations, spoons and bowls and other appropriate materials;
b) material to enable safer smoking and inhalation of drugs, such as pipes, stems, metal screens, alcohol wipes and lip balm;
c) condoms and other safer sex materials, such as water-based lubricants and dental dams, as well as information about reducing the risks of HIV and other sexually transmitted infections; and
d) first aid in emergency situations.

(3) Staff of sterile syringe programmes may provide information including, but not limited to, the following:
a) drug dependence treatment services and other health services;
b) means of protection against transmissible diseases, including blood-borne diseases such as HIV;
c) the risks associated with the use of controlled substances;
d) harm reduction information specific to the drug being used, including safe injecting and inhaling practices;
e) legal aid services;
f) employment and vocational training services and centres; and
g) available support services for people with drug dependence and their families.

(4) The state shall ensure access to sterile syringes for people who require them. Where sterile syringes are not otherwise available and there is demand, the state shall establish a sterile syringe programme out of public funds. The state may distribute sterile syringes through public health facilities or provide funding to community organizations to operate sterile syringe programmes.

Supporting effective outreach work by harm reduction programmes

(5) "Outreach work" means a community-oriented activity undertaken to contact and provide information and services to individuals or groups from particular populations at risk of blood-borne diseases, particularly those who are not effectively contacted or reached by existing information and services or through traditional health care channels.

(6) "Outreach workers" include paid social or public health workers or unpaid volunteers (including peers) of governmental or non-governmental facilities.

(7) Outreach workers may include people who currently use drugs, people who formerly used drugs or people who do not use drugs and are trusted by people who use drugs.

Recommendation 5: Preclude criminal and administrative liability for harm reduction programmes

The harm reduction and outreach activities of non-governmental organizations, targeting people who use drugs, such as programmes providing sterile syringes or other equipment to reduce harms associated with drug use (including HIV transmission), should be clearly exempt from possible liability. In particular, the law should make clear that those operating syringe exchange programmes are not targeted under either the "propaganda and advertising" provisions of the and the Law "On Drugs" (Article 24) and *Code*

of Administrative Offences (Article 321) or the "incitement of drug use" provision of the *Criminal Code* (Article 261). In addition, articles of the *Criminal Code* (Article 259) and the *Code of Administrative Offences* (Article 320) governing "possession" of drugs should be amended in order to state clearly that NSP workers do not face any criminal or administrative liability for possessing residual quantities of drugs in used injection or other equipment. To achieve this, specific legislative provisions such as the following could be inserted in the *Criminal Code* and *Code of Administrative Offences*:[785]

Exemption from criminal liability for sterile syringe and other harm reduction programmes

Nothing in this or any other law prevents the supply of syringes and other related material, or the giving of advice, information or instruction on the safe use of syringes and other related material, by staff of a sterile syringe programme or other programme aimed at reducing harms associated with the use of prohibited narcotics or psychotropic substances.

Decriminalization of possession of residual amounts of drugs, including in used syringes

A person who is in possession of any residual amount of a prohibited narcotic or psychotropic substance that is contained in or on a syringe or other equipment used to ingest such a substance does not, by the mere fact of that possession, commit an offence under this or any other law.

Recommendation 6: Remove intoxication as aggravating factor for criminal liability

According to the *Criminal Code* (Article 54), being intoxicated (by drugs or alcohol) while committing a crime is an aggravating circumstance that heightens liability and sentence. However, whether or not a person is intoxicated does not affect the gravity of the harm of his or her crime, so it should not be considered as making the crime more serious. Rather, such a provision effectively discriminates against people accused of crimes based on their health status (i.e., dependence of drugs or alcohol), imposing harsher penalties for a given crime on people with this health condition. Article 54 should be repealed.

Recommendation 7: Eliminate or narrow use of compulsory drug testing

The national expert group recommended prohibiting drug testing except perhaps in very limited circumstances list of persons subjected to testing must be strictly defined in one regulatory act. Currently, compulsory testing for drugs may be imposed in situations of drug use in public places (*Code of Administrative Offences*, Article 336-2), as well in the event a person is intoxicated in public places, at work or some other specified circumstances, pursuant to an order of the Ministry of Health.[786] Furthermore, as noted above, the *Code of Administrative Offences* (Article 326) imposes administrative liability, in the form of fines, for "avoidance of medical examination and treatment by the persons using drugs and psychotropic substances without physician prescription". Effectively, therefore, Kazakh law gives police considerable powers to impose compulsory testing for drugs on a wide range of people, beyond those situations where such intervention may be justifiable in order to prevent serious risk of harm to oneself or to others. Mere use of alcohol or drugs does not, by itself, establish this. To eliminate unjustifiably broad provisions for compulsory drug testing:

- Articles 326 and 336-2 of the *Code of Administrative Offences* should be repealed; and
- the Ministry of Health "Instruction on medical testing to establish drug use and state of intoxication" (Order No. 446) should be revised to narrow the authorization of involuntary drug testing to very limited circumstances. (See the "Discrimination" section below for recommendations on limiting the use of drug testing in the employment or educational contexts.)

785 See Legislating for Health and Human Rights: Model Law on Drug Use and HIV/AIDS, Module 3: Sterile syringe programs, pp. 19-21.

786 Ministry of Health, "Instructions on Medical Examination for Fact-Finding of Psychoactive Substance Use and Intoxication", Order No. 446 (11 June 2003).

Recommendation 8: Repeal administrative liability for avoiding testing and treatment

It is recommended to amend Articles 326-328 of the *Code of Administrative Offences*, which impose administrative liability in various situations of avoiding examination and treatment. Article 326 makes liable for avoiding examination and treatment those who are in contact with HIV-positive people, people with HIV, STIs, tuberculosis (after written warning by public health officials), and those who are dependent on drugs or alcohol or about whom there is "sufficient information" that they use drugs without prescription. Article 327 imposes liability for avoiding treatment on those with diseases that pose a "serious hazard" to others (which is defined to include HIV, even though it is not casually communicable), as well as those who were in contact with such people and have received a written warning issued by health care officials. Finally, Article 328 imposes liability on a person with a disease that is a "serious hazard" to others for not disclosing the source of infection and naming past contacts.

These provisions are overly broad, essentially imposing compulsory testing and treatment, upon pain of penalty, even when there is no imminent risk of harm to others and even when a person is fully competent to make his or her own decisions about whether to seek testing or treatment. The infringement on personal privacy, security of the person and, potentially, liberty if a penalty were imposed, is disproportionate and not shown to be necessary. Intervening to compel testing or treatment may only be potentially justifiable in exceptional circumstances when an independent authority, based on appropriate and adequate evidence, determines that intervention is necessary to prevent a significant, imminent risk of harm to other identifiable person or persons, or in cases where the person himself or herself is not competent to make an informed decision about whether or not to seek testing or treatment. Even where intervention to impose testing or treatment may possibly be justified, the objective should be to protect the individual or others from harm, not to impose penalties, which is the current approach reflected in Articles 326-328. These provisions should be repealed; other measures in law to authorize coercive intervention in exceptional circumstances, with appropriate safeguards, are a preferable approach.

Recommendation 9: Eliminate HIV and STI-specific criminal law

Articles 115 and 116 of the *Criminal Code*, which specifically provide for punishment for transmission and exposure to "venereal diseases" and HIV, should be repealed. In the case of intentional transmission of venereal or HIV infection, this could be dealt with as infliction of bodily harm that is covered by other articles of the *Criminal Code*.

Drug dependence treatment

Recommendation 10: Adopt a new law on drug dependence treatment

As noted above, in Kazakhstan there is no law on drug dependence treatment; the issue is governed by several legislative and regulatory acts. The national expert group has recommended drafting and adopting a comprehensive Law "On Drug Treatment and Narcological Care" that would address all necessary issues of improving and scaling up of drug dependence treatment options (including recommendations such as those below).[787]

Recommendation 11: Opioid substitution treatment

Opioid substitution treatment is one important component of drug dependence treatment, and recognized in international best practice as key to HIV prevention among people who inject drugs. Methods of drug dependence treatment need to be expanded and brought in line with international standards and good practice. It is recommended that after the initial test period, the Ministry of Health promptly scale

787 The process of developing such a law should include the involvement of NGOs and people who use and/or have used drugs, as the intended beneficiaries of such a law. Useful guidance in drafting some elements of such a law may be found in Legislating for Health and Human Rights: Model Law on Drug Use and HIV/AIDS, and in particular Module 2 (Treatment for drug dependence) of that resource.

up the OST programmes. As noted above, opioid substitution treatment is specified in many regulatory acts of the Republic of Kazakhstan. Additional legislation is not needed to move ahead with this important health service, which is critical to drug dependence treatment and to HIV prevention among people who inject drugs. Although not necessary, it may be useful to help support and sustain this programme to have a clear legislative basis, in which case an additional step could be to amend the Law "On Drugs" (and adopt the new law on drug treatment and narcological care) to add some provisions providing a clear framework for substitution therapy, one that protects and promotes the human rights of patients receiving OST.[788]

Recommendation 12: Protect anonymity and confidentiality in drug dependence treatment

The national expert group has recommended expanding provision of anonymous drug treatment and rehabilitation services. They have further specified that when personal identification is needed, it is necessary to strictly observe confidentiality; failure to respect confidentiality should attract legal liability. The national experts have recommended that Kazakh legislation be amended to include explicit provisions strengthening the confidentiality of health information of patients receiving narcological assistance. Provisions such as the following should be added to the legislation:[789]

Confidentiality of patients in drug dependence treatment

(1) The confidentiality of all health care information shall be respected. Records of the identity, diagnosis, prognosis or treatment of any patient which are created or obtained in the course of drug dependence treatment:
a) are confidential;
b) are not open to public inspection or disclosure;
c) shall not be shared with other individuals or agencies without the consent of the person to whom the record relates; and
d) shall not be discoverable or admissible during legal proceedings.

(2) No record referred to in Section (1) may be used to
e) initiate or substantiate any criminal charges against a patient; or
f) act as grounds for conducting any investigation of a patient.

(3) Programme staff cannot be compelled under any other law to provide evidence concerning the information that was entrusted to them or became known to them in this capacity.

(4) All use of personal information of patients and programme staff in research and evaluation shall be undertaken in conditions guaranteeing anonymity, and any such information shall also be governed by Section (2) of this article.

Recommendation 13: Eliminate or limit compulsory drug dependence treatment

It is recommended to review the effectiveness of compulsory drug dependence treatment in Kazakhstan, with a view to reforming existing legislation that has broad provisions for compulsory treatment. International organizations underline the principle that drug dependence treatment should generally be voluntary.[790] As a general proposition, compulsory medical treatment violates human rights, including to liberty, security of the person and privacy,[791] and should be applied only in extreme, clearly defined cases with a view to preventing a person from causing imminent serious harm to self or to others.

788 For model provisions that could be usefully incorporated into law to support OST programs that reflect human rights principles, see Legislating for Health and Human Rights: Model Law on Drug Use and HIV/AIDS, Module 2: Treatment for drug dependence, pp. 25-33.

789 See Legislating for Health and Human Rights: Model Law on Drug Use and HIV/AIDS, Module 2: Treatment for drug dependence, pp. 20-22.

790 UNODC and WHO, Principles of Drug Dependence Treatment, Discussion paper, March 2008, p. 9.

791 International Covenant on Civil and Political Rights, 999 U.N.T.S. 171 (1966), Articles 7, 9 and 17; Universal Declaration of Human Rights, UN General Assembly Resolution 217A (III), UN Doc. A/810 (1948), Articles 3 and 12.

Currently, various legal instruments in Kazakhstan affect compulsory drug dependence treatment;[792] several of these may require amendment in order to narrow appropriately the scope of compulsory drug dependence treatment. Under current Kazakh law, compulsory drug dependence treatment may be imposed in a various circumstances. There is a general possibility of administrative liability and penalty of a person who avoids treatment if there is "sufficient information" regarding their drug use (*Code of Administrative Offences*, Article 326). As well, compulsory drug dependence treatment may be imposed as part of sentencing for an administrative or criminal offence. A person convicted of certain administrative offences may be ordered to undergo compulsory treatment (for up to two years) in addition to an administrative penalty.[793] Furthermore, a person convicted of committing a criminal offence while intoxicated may be ordered to undergo compulsory treatment *in addition to* a penalty of imprisonment; Kazakh law does not currently provide for drug dependence treatment as an *alternative* to imprisonment. In this respect, Kazakh law fails to take advantage of flexibility offered under international drug control treaties.[794]

The national expert group and the technical advisors have offered a number of recommendations to limit the use of compulsory drug treatment, as follows:

- As noted above, repeal or at least narrow Article 326 of the *Code of Administrative Offences*, which imposes liability for avoiding treatment for drug dependence, among other things.

- In addition, according to the national expert group, Presidential Decree No. 2184 ("On compulsory treatment of alcohol, drug and toxic substance abuse") should be repealed.

- In conformity with the international drug control treaties, the *Criminal Code* should be amended to allow such drug dependence treatment to be an *alternative* to imprisonment in at least some cases, rather than an additional sentence. As an alternative to imprisonment, persons with drug dependence convicted of administrative offences or less serious criminal offences could be treated in "voluntary" medical and social rehabilitation departments, under the supervision (e.g., by the Ministry of Internal Affairs) similar to that imposed on persons who are conditionally discharged following a prosecution.[795]

Recommendation 14: Reform registration of people who use drugs and protect confidentiality

In order to protect and respect human rights, and to remove a reason for people to avoid seeking out treatment for drug dependence or help with problematic drug use, Kazakhstan should abolish a central registry of people who use drugs and are dependent on it, which registry is then used in ways that can infringe human rights. To this end, the relevant Order of the Ministry of Health, stipulating drug use registration should be amended and registration repealed.[796] (Obviously, centres providing drug dependence treatment need to maintain some individualized information about patients in order to deliver treatment properly, and can and should continue to do so, as health facilities do with other patients receiving other kinds of health services, with proper protections for the confidentiality of patients' health information — including not disclosing information to law enforcement or other agencies upon their request.

792 Law "On Medical and Social Rehabilitation of Drug Addicts", No. 325-II (27 May 2002); Law "On Compulsory Treatment of Alcohol, Drug, and Toxic Substances Abuse", No. 2184 (7 April 1995); Law "On Drugs, Psychotropic Substances, Precursors and Their Illicit Traffic and Abuse Countermeasures", Chapter 3 (Medical and Social Care for Drug and Toxic Substances Addicts), Articles 32-37.

793 Code of Administrative Offences, Article 59.

794 Specifically with respect to drug offences, the international drug control treaties 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: Single Convention on Narcotic Drugs, 1961, 520 UNTS 331, as amended by the 1972 Protocol, Article 36(2); Convention on Psychotropic Substances, 1971, 1019 UNTS 175, Article 22; Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances, 1988, Article 3(4).

795 Obviously, the "voluntary" nature of the treatment is limited by the fact that the alternative would be to be imprisoned. For some guidance on legislative provisions that could implement an approach but with a greater degree of voluntariness in undergoing treatment — one which would avoid making drug dependence treatment compulsory, while still taking advantage of the person's contact with the criminal justice system to encourage voluntarily starting treatment — see Legislating for Health and Human Rights: Model Law on Drug Use and HIV/AIDS, Module 1: Criminal law issues, pp. 23-28.

796 Order of the Ministry of Health of the Republic of Kazakhstan "On the Rules of referral, terms of care and assistance to people with drug dependence in medical and social rehabilitation centres (departments)", No. 638 (18 August 2004).

Recommendation 15: Prevent and treat overdoses

In order to prevent deaths and other serious harms from overdoses among opioid users, outreach workers (including those working for non-governmental organizations and including "peers" who are themselves persons who use or have previously used drugs), should be given the legal right to distribute and administer medications such as naloxone in cases of overdose. This could be done by introducing provisions such as the following into the *Law on drugs, psychotropic substances, precursors and their illicit traffic and abuse countermeasures*:[797]

> **Administration of an opioid antagonist**
>
> (1) The Ministry of Health must make provision for the appropriate training of outreach workers in the administration of opioid antagonists.
>
> (2) An outreach worker may administer an opioid antagonist to another person if:
> c) the worker believes, in good faith, that the other person is experiencing a drug overdose; and
> d) the worker acts with reasonable care in administering the drug to the other person.
>
> (3) An outreach worker who administers an opioid antagonist to another person pursuant to Section (1) shall not be subject to civil liability or criminal prosecution as a result of the administration of the opioid antagonist.

In order to preclude overdose complications in prisons, it is recommended to allow peer educators among prisoners and prison staff to administer naloxone in case of overdose in penitentiary institutions, and train them to use this emergency response medication.

Health care and HIV testing and treatment

Recommendation 16: Promote continuity of care

The national expert group has recommended developing partnerships between the HIV, drug dependence, tuberculosis, and hepatitis C treatment facilities to regulate transfer of patients with HIV and drug-dependent people from closed institutions into other medical facilities.

Recommendation 17: Ensure informed consent to HIV testing

As mentioned above, a Ministry of Health order specifies HIV testing should be done with informed consent and counselling.[798] However, there is no specific requirement for informed consent in the Law "On Prevention and Treatment of HIV and AIDS". Thus, it is recommended introducing into the law a provision along the lines of the following:

> No test for HIV or other blood-borne infection shall be undertaken except with the informed voluntary consent of the person being tested, which informed consent should be clearly documented in writing.

Recommendation 18: Compulsory testing and treatment for HIV and STIs

Currently, Kazakh law includes very broad provisions for imposing involuntary testing for, and treatment of, HIV and STIs. These provisions unjustifiably violate human rights (e.g., right to security of the person, right to privacy) and do not accord with international best practice recommendations that HIV (and STI) testing should generally be voluntary. The following reforms are recommended:

797 See Legislating for Health and Human Rights: Model Law on Drug Use and HIV/AIDS, Module 6: Outreach and information, pp. 14-15.

798 Ministry of Health, Order No. 227 (9 March 2004).

- Repeal the portion of Article 5 of the Law "On prevention and treatment of HIV and AIDS" which specifies that prisoners are to undergo compulsory HIV testing.
- Repeal Article 6 of the Law "On prevention and treatment of HIV and AIDS", which states that all Kazakh citizens, foreigners, and stateless persons are obliged to undergo confidential medical examination if there are sufficient grounds to believe they may be infected with HIV, upon request of health care bodies, the prosecutor's office, and investigative and judicial bodies.
- Repeal Article 7-1 of the Law "On Health and Disease Control" and the 2007 Ministry of Health Order "On HIV Prevention in the Republic of Kazakhstan" that impose HIV testing for all foreigners who enter the country for more than 6 months or for permanent residence, and their deportation if found HIV-positive and avoiding surveillance.
- Repeal the provisions of the Joint Order of the Ministry of Health and the Ministry of Defence in 2005 according to which military personnel must undergo HIV testing upon their entry to the service and 6 months after.[799]

- Article 17 of the Law of Kazakhstan "*On Health Protection*" provides for examination, treatment, and medical intervention without consent of those with diseases that pose a "serious hazard" to others (which is defined to include HIV).[800] This provision should be amended to clarify that testing and treatment for HIV (and other STIs) cannot be imposed involuntarily simply by request of the public health services. Rather, if testing or treatment is ever to be imposed without consent, then it requires a process clearly set out in law, with a requirement that such measures be taken only in exceptional circumstances and with adequate justification that must be considered by an independent, judicial body, and with the most limited infringement of human rights possible.[801]
- Amend Articles 326-328 of the *Code of Administrative Offences* ("Responsibility for avoiding treatment") so as to remove potential legal liability of the person with HIV for avoiding examination and treatment.

Recommendation 19: Ensure access to free and confidential STI treatment

The technical consultants and the expert group recommend to cancel registration of persons with STIs, and introduce free, voluntary and confidential STI testing and treatment.

Recommendation 20: Strengthen harm reduction measures

Given the significant role of injecting drug use in the HIV epidemic in Kazakhstan, it is important that the Law "On prevention and treatment of HIV and AIDS" reflect and support measures to prevent HIV and other harms to which people who use drugs, especially by injection, are vulnerable, in accordance with international standards and recognized good practice. To this end, the Law "On Prevention and Treatment of HIV and AIDS" should be strengthened by legislatively mandating measures to reduce harms, including HIV infection, among people who use drugs and prisoners. This should include directives specifically to government bodies and agencies that have particular responsibilities in this area, such as the Ministry of Health and Ministry of Justice, as well as clearly directing law enforcement bodies (e.g., the Committee on combating drug trafficking and control of drug turnover) to cooperate with other government bodies and with non-governmental organizations to ensure the effective delivery and operation of harm reduction services (e.g., sterile syringe programmes, OST).

Recommendation 21: Other patient rights

While the Law "On public health care" and the Law "On health protection" currently recognize some important rights of patients, it should be strengthened by explicitly adding a provision such as the following:[802]

799 Joint Order of the Ministry of Health and the Ministry of Defence No.562 (04 November 2005) and No.342 (19 September 2005).

800 Law "On health protection", Article 17.

801 Guidelines such as the UN's Siracusa Principles on permissible limitations on human rights should be complied with in any legislative provision that would allow involuntary testing or treatment. It is worth noting that the Law on public health care (Article 31) already recognizes that a patient should have the right to a lawyer or other representative to help ensure protection of his or her rights, so introducing amendments designed to strengthen the human rights not to be subjected to compulsory testing or treatment should build on that.

802 See Legislating for Health and Human Rights: Model Law on Drug Use and HIV/AIDS, Module 2: Treatment for drug dependence, pp. 18-19.

Every patient has the right:

a) to treatment and provided in accordance with good clinical practice;
b) to treatment without discrimination;
c) to meaningful participation in determining his or her own treatment goals;
d) to meaningful participation in all treatment decisions, including when and how treatment is initiated and withdrawal from treatment;
e) to exercise his or her rights as a patient;
f) to confidentiality of medical records and clinical test results.

Prisons

Recommendation 22: Implement harm reduction programmes, including needle and syringe programmes, in prisons

It is recommended to introduce amendments and appendices in the Internal Rules of Prisons and Detention Facilities, and the Official Order regulating health care for accused and convicted persons, with the aim of introducing needle and syringe programmes, and the distribution of condoms and sterilizing agents, for the purpose of protecting prisoners health including preventing HIV and other blood-borne diseases. The Internal Regulations' provisions prohibiting prisoners from possessing needles and syringes should be repealed, as these represent a barrier to implementing needle and syringe programmes in prisons. Provisions such as those below could be inserted into the Law "On prevention and treatment of HIV and AIDS" and/or the *Penal Code*, or could be prepared as "Rules for Syringe Exchanges and other HIV Prevention Measures in Prisons and Detention Facilities".[803]

Distribution and possession of condoms and other safer sex materials in prisons

(1) The Ministry of Health and the Ministry of Justice shall ensure that condoms and other safer sex materials, along with appropriate information on their proper use and on their importance in preventing the spread of HIV infection and other sexually transmitted infections, are made available and easily accessible to prisoners in a manner that protects their anonymity.

(2) The Ministry of Health shall develop a plan for the disposal of used condoms that protects the anonymity of prisoners and the health of prison officers.

(3) The distribution and possession of condoms and other safer sex materials in prisons in accordance with this law shall not constitute a criminal nor administrative offence, nor are condoms and other safer sex materials admissible as evidence of sexual relations for the purposes of determining any criminal or administrative offence.

Authorization of harm reduction programmes

(1) Harm reduction programmes shall be implemented in all prisons according to the provisions set out herein, with the objective of reducing harms associated with unsafe use of drugs, including the risk of transmission of HIV or other blood-borne diseases.

(2) In order to prevent the spread of blood-borne diseases and minimize the health risks associated with drug use by prisoners, either the Ministry of Health or a local prison authority may authorize a specified person or organization (including non-governmental organisations) to deliver harm reduction programmes, including measures to supply sterile syringes and other related material to prisoners, as well as condoms and other materials to reduce the risks of HIV and other sexually transmitted infections.

803 See Legislating for Health and Human Rights: Model Law on Drug Use and HIV/AIDS, Module 5: Prisons, pp. 25-30.

Information

(1) Staff of harm reduction programmes may also provide information including, but not limited to, the following:
(a) drug dependence treatment services and other health services;
(b) means of protection against transmissible diseases, including blood-borne diseases such as HIV;
(c) the risks associated with the use of controlled substances;
(d) harm reduction information specific to the drug being used, including safe injecting and inhaling practices;
(e) legal aid services;
(f) employment and vocational training services and centres; and
(g) available support services for people with drug dependence and their families.

Distribution and possession of sterile syringes and related material

(2) An authorized person or organization may distribute sterile syringes and related material via one or more of the following means:
(a) prison nurses or physicians based in a medical unit or other area(s) of the prison;
(b) prisoners trained as peer outreach workers;
(c) non-governmental organizations or health professionals who enter the prison for this purpose;
(d) one-for-one automated sterile syringe-dispensing machines.

(3) Wherever possible, sterile syringes and related material shall be made available to prisoners without the necessity of the prisoner identifying himself or herself to prison authorities.

(4) The Ministry of Justice, in consultation with the Ministry of Health shall establish rules for the safe storage of syringes possessed by prisoners in accordance with this law.

(5) The sterile syringe programme shall include measures to encourage safe disposal of syringes and monitor the number of syringes distributed and the number in storage.

(6) Sterile syringes and related material distributed by harm reduction programmes shall be used only in accordance with this law and any other applicable Regulations or institutional policies established by the relevant authority.

(7) The distribution and possession of syringes and related material in prison in accordance with this law shall not constitute a criminal nor administrative offence, nor shall such items be admissible as evidence of illegal drug use for the purposes of determining any criminal or administrative offence.

Availability of bleach as a disinfectant

(1) Bleach and instructions on using bleach as a disinfectant shall be made available in accordance with this law and any other applicable Regulations or institutional policies established pursuant to this law.

(2) Any such Regulations or policies will:
(a) encourage participation of prisoners and their assistance in bleach distribution;
(b) ensure that bleach is available to prisoners in ways that preserve prisoners' anonymity; and
(c) ensure that in no instance shall a prisoner be required to approach a staff member in order to obtain bleach.

(3) Bleach distributed pursuant to this law shall be used only in accordance with this law and any other applicable Regulations or institutional policies established pursuant to this law.

(4) The distribution and possession of bleach in prison in accordance with this law shall not consti-

tute a criminal nor administrative offence, nor shall such items be admissible as evidence of illegal drug use for the purposes of determining any criminal or administrative offence.

Information and education programmes regarding HIV/AIDS, other blood-borne diseases and drug dependence treatment in prisons

(1) The Ministry of Health shall develop and implement information and education programmes in every prison to help prevent the spread of HIV, other blood-borne diseases, and to address drug dependence among prisoners.

(2) In developing such programmes, the Ministry of Health shall use materials that are likely to be effective in reducing transmission of blood-borne diseases within prisons and outside prison following the release of prisoners, as well as providing information on treatment, care and support.

(3) Such programmes required by Section (1) may include peer education and use of non-Ministry of Justice personnel, including delivery of these programmes by community-based organizations.

(4) Materials shall, as much as possible, be available in the languages of the relevant populations, shall take into account the literacy level of the relevant populations, and shall be sensitive to the social and cultural needs of the relevant populations.

Responsibility of the Ministry of Health for providing training and education

(1) The Ministry of Health is responsible for ensuring:
(a) that training and education are provided to staff and prisoners on a regular basis, and that such training and education include the principles of standard precautions to prevent and control blood borne diseases; the personal responsibility of staff and prisoners to protect themselves and others at all times; and information on post-exposure prophylaxis, if available;
(b) that training and education provided to prisoners also include available services and treatments; and peer education and counselling programmes that include the meaningful participation of prisoners as counsellors; and
(c) that prisoners and staff who may be exposed to blood and body fluids receive training in universal precautions.

Recommendation 23: Opioid substitution treatment in prisons

Given the high prevalence of drug dependence among those imprisoned, the significance of risky drug use practices in contributing to the HIV epidemic, and the importance of providing access to health services that respect human rights and help promote the highest attainable standard of health for all persons, it is recommended that Kazakhstan implement OST in prisons as soon as it is made available outside prisons, as one important element of programmes for addressing drug dependence.

Explicit reference to providing access to OST to drug-dependent persons in prisons could be worded as follows (and could also be inserted into legislation such as the *Penal Code*):[804]

Opioid substitution treatment programmes in prison

(1) The Ministry of Health, with the support and cooperation of the Ministry of Justice, shall establish opioid substitution treatment programmes in all prisons.

(2) Prisoners with opioid dependence shall be eligible for opioid substitution treatment in accordance with opioid substitution treatment guidelines applicable in the community.

(3) Opioid substitution treatment shall be available for free on imprisonment and throughout the duration of imprisonment.

(4) Opioid substitution treatment shall not be restricted to those on a course of opioid substitution treatment prior to imprisonment; all prisoners shall be entitled, if eligible, to being on opioid substitution treatment while incarcerated.

(5) Participation in the opioid substitution treatment programmes shall be offered on a voluntary basis to all prisoners with opioid dependence.

(6) Opioid substitution treatment programmes may include a variety of approaches, including maintenance treatment.

(7) The programme shall ensure that staff members, prison officers, policy makers and prisoners have factual information regarding opioid substitution treatment.

(8) The programme shall develop a comprehensive discharge planning system for prisoners nearing release, including a system for referral to opioid substitution treatment programmes in the general community.

804 See Legislating for Health and Human Rights: Model Law on Drug Use and HIV/AIDS, Module 5: Prisons, pp. 30-32.

Recommendation 24: Ensure access to rehabilitation for drug-dependent prisoners

The national expert group has recommended that the Government adopt legislative regulations, and arrange in practice, for medical and social rehabilitation programmes for drug-dependent prisoners.

Recommendation 25: Eliminate compulsory HIV testing of prisoners and ensure equivalent access to voluntary HIV testing and treatment in prisons

It is recommended to abolish obligatory HIV testing of prisoners, as this is contrary to human rights and international best practice.[805] Furthermore, to ensure the right of access to equivalent health services, authorities responsible for correctional facilities need to implement universal access to antiretroviral therapy and other needed medications and treatment for HIV-positive prisoners. To this end, a provision such as the following should be inserted into the Law "On Prevention and Treatment of HIV and AIDS" and/or the *Penal Code*:[806]

Right to equal and adequate health care for prisoners

(1) HIV testing for prisoners is conducted only on a voluntary basis.

(2) A prisoner who has tested positive for infection with HIV is entitled to adequate health care, counselling and referrals to support services while in prison.

(3) Health practitioners shall provide prisoners with protection of their physical and mental health and treatment of disease of the same quality and standard as is afforded to those who are not imprisoned or detained.

While it is recommended that there be explicit reference to HIV, ideally, such an amendment would be worded more broadly to extend to needed health care services and medications beyond just HIV-specific care.

The national expert group has also recommended that the correctional authorities, together with other interested public bodies and NGOs, develop a Programme on Social Support to ensure continuity of care for prisoners with HIV upon release from prison.

805 International Guidelines on HIV/AIDS and Human Rights (2006 Consolidated Version), Guideline 3 ("Public Health Legislation"), para. 20(b) and Guideline 4 ("Criminal Laws and Correctional Systems'), para. 21(e).

806 See Legislating for Health and Human Rights: Model Law on Drug Use and HIV/AIDS, Module 5: Prisons, pp. 16-17.

Recommendation 26: Protect confidentiality of prisoners' health information

It is recommended to introduce amendments to the *Penal Code,* including adding provisions regarding the obligation on prison system personnel to maintain the confidentiality of medical information of prisoners, including their HIV status. A provision such as the following should be inserted into the *Penal Code*:

> **Confidentiality**
>
> (1) All information on the health status and health care of a prisoner is confidential, and all health care procedures shall be designed so as to preserve the confidentiality of prisoners.
>
> (2) Information referred to in Section (1) shall be recorded in files available only to health practitioners and not to non-health care prison staff. No mark, label, stamp or other visible sign shall be placed on prisoner's files, cells or papers that could indicate his or her HIV status, other than necessary notations inside the medical file in accordance with standard professional practice for recording clinically relevant information about a patient.
>
> (3) Information referred to in Section (1) may only be disclosed:
> (a) with the prisoner's consent, or
> (b) where warranted to ensure the safety of other prisoners or staff,
> in accordance with the same principles as generally applied in the community applying to the disclosure.

Recommendation 27: Eliminate discrimination against prisoners with HIV or drug dependence

To eliminate discrimination currently embedded in the law, the *Penal Code* should be amended in a number of ways, as follows:

- Repeal the prohibition on transferring prisoners who are ordered to undergo compulsory drug dependence treatment to better conditions (lower security institutions).
- Remove HIV-positive status and the fact of not completing a full course of treatment for drug dependence or STIs from Articles 73 (and others as follows) as factors that restrict a prisoner's right to transfer and movement.

Recommendation 28: Provide for early release for prisoners participating in HIV prevention activities

The national expert group has recommended that persons actively participating in HIV prevention efforts or vocational activities and training regarding HIV prevention be eligible to apply, under Article 109(4) of the *Penal Code*, for early parole.

Discrimination

As noted above, legislation of Kazakhstan includes provisions prohibiting, in general terms, discrimination against people based on HIV-positive status. Yet at the same time, discrimination is a reality and Kazakh law itself contains discriminatory provisions in other areas. Legal protections against discrimination are important elements of successfully addressing the marginalization that contributes, in multiple ways, to people's vulnerability to HIV and to experiencing even more severely the impact of HIV infection. Legislation can be strengthened in several ways in this regard in order to comply with human rights principles.

Recommendation 29: Prohibit HIV testing in employment or educational settings

Current Kazakh law already prohibits refusing to employ someone or dismissing someone from employment based on HIV status. However, it would be useful to recognize explicitly that requiring HIV testing before or during employment or attendance at an educational institution amounts to unjustified discrimination.[807] It is recommended to introduce into the *Labour Code* a provision prohibiting employers from conducting HIV testing as a condition for employment. Alternatively (or in addition), a legislative amendment to the Law "On Prevention and Treatment of HIV and AIDS" should prohibit such practices. A provision could be worded as follows:

> Discriminating against a person, or against a relative or associate of a person, on the basis of real or perceived HIV infection or AIDS diagnosis, is prohibited, including but not limited to such contexts as employment or education. For greater clarity, it is unlawful discrimination to require that a person be tested for HIV as a condition of employment or enrolment in an educational institution, either before or during employment or enrolment.

Recommendation 30: Prohibit discrimination against drug-dependent persons in employment or educational settings

Kazakh legislation restricts rights of people who use drugs and who are registered with drug dependence treatment facilities in obtaining a driver's license[808] and in working in certain jobs that are high-risk as well as in pharmacological facilities.[809] As the national experts group has noted, there are contradictions between the cited Ministry of Health policy and broader government policy on the issue of prohibition of employment to certain jobs of people who previously used drugs: the Ministry of Health order provides that such employment restrictions do not depend on the current state of person's health, but the Government resolution states that for the person in remission restrictions on many types of activities and driving are lifted.[810] It is recommended to review current regulatory acts in order to ensure no unjustified discrimination in employment based on drug use.

More broadly, legislators need to address the question of discrimination in employment, but also in educational institutions, based on drug dependence. Requiring drug testing *before* employment or enrolment in an educational institution is also unjustified discrimination based on health condition. Requiring testing for drug use *during* employment may only be potentially justifiable in quite limited circumstances, such as limiting testing to positions that are safety-sensitive and then only in cases where there are reasonable grounds to suspect impairment or possibly random drug testing of persons returning to work after receiving drug dependence treatment. It is recommended that the law (perhaps the Law "On Drugs") be amended to include a provision along the lines of the following:[811]

> **Discrimination based on drug use**
>
> (1) Absent a reasonable justification given the circumstances of the case, it is prohibited to discriminate against a person, or a relative or associate of the person, on the ground that the person uses or has used drugs, or is perceived to use or have used drugs.
>
> (2) It is unlawful discrimination to require that a person undergo drug testing as condition of enrolment in an educational institution, either before or during enrolment.
>
> (3) It is unlawful discrimination to require that a person undergo drug testing as a pre-condition of employment. Making drug testing a condition of continued employment is permitted only in positions, as designated by [suitable government authority], where impairment while at work may

807 E.g., see UNAIDS/OHCHR, International Guidelines on HIV/AIDS and Human Rights, para. 149. Similar analysis would apply to discrimination against someone based on something like infection with hepatitis B or C virus (HBV, HCV) or on the basis of a sexually transmitted infection. Given modes of transmission, many people who inject drugs are vulnerable to infection with other blood-borne diseases such as HBV or HCV, in addition to HIV, and may face discrimination on that basis, as has been observed in other jurisdictions. In making amendments to strengthen protection against HIV-related discrimination in an area such as employment or educational contexts, it would be advisable to explicitly include protection against discrimination based on such other diseases.

808 Guidelines on Obligatory Preliminary and Regular Medical Examination of Workers Exposed to Harmful, Dangerous, and Unfavorable Production Factors and Professional Fitness Procedure, para. 13.2, approved by the Ministry of Health, Order No. 243 (12 March 2004).

809 Ibid., para 12.4, and Government of Kazakhstan, Resolution "On Approval of a List of Medical Psychiatric Contra-Indications for Certain Professional Activities and the High Risk Works", Resolution No.668 (18 June 2002).

810 Ministry of Heath, Order No. 243; Government of Kazakhstan, Resolution No.668.

811 See Legislating for Health and Human Rights: Model Law on Drug Use and HIV/AIDS, Module 7: Stigma and discrimination, pp. 13-15.

pose a significant risk of harm to the individual employee or to others *and* where there are reasonable grounds to suspect that the individual employee may be impaired by drug use.

Recommendation 31: Respecting and protecting family relationships

The Law "On Prevention and Treatment of HIV and AIDS" prohibits restricting the "rights and legitimate interests" of people with HIV based on HIV-positive status and "equally, restriction of housing and other rights and legitimate interests of family members of the HIV-infected persons".[812] Yet people living with HIV are denied the right to adopt children, a blanket restriction which is not justified.[813]

People who use drugs are also denied the right to adopt.[814] In addition, mere drug dependence can be a basis for depriving someone of custody of a child in cases of concern about child neglect or abuse: the Law "On Marriage and Family" states that parents may be deprived of their parental rights if they "are recognized in due order as person abusing alcohol, drugs, and substances".[815] If drug use or dependence is *per se* assumed to be a basis for depriving parents of their children, this would amount to discrimination simply on the basis of a health condition that is not justified; rather, in every case there must be regard for individual circumstances, not simply assumptions or prejudices about people who use drugs or are drug-dependent.

The following reforms are recommended:

- Article 67(5) of the Law "On Marriage and Family" should be amended to clarify that, in cases of concern about child abuse or neglect, drug dependence should not be assumed to be *per se* sufficient grounds to deprive someone of parental rights, but rather a careful analysis of the individual circumstances is required.
- The government resolution that lists HIV and drug dependence as barriers to adopting or receiving custody of a child should be amended to delete these conditions from the list.

812 Law "On Prevention and Treatment of HIV and AIDS", Article 7(4).

813 Government Resolution, "On the List of Diseases Preventing from Child Adoption, Guardianship (Patronage), Foster Care", No.842 (24 June 1999), para. 3.

814 Ibid.

815 Law "On Marriage and Family"[О браке и семье], No.321-I, (17 December 1998), Article 67(5).

Annex:

Draft Law prepared by the national expert group of the Republic of Kazakhstan

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Law "On Amendments and Addenda to Some Legislative Acts on HIV/ AIDS and the Prevention and Treatment of Drug and Toxic Substances Abuse"

Article 1. The following amendments are hereby made to the following acts:

1. In the *Code of the Republic of Kazakhstan of Administrative Offences* (30 January 2001), (Vedomosti Parlamenta Respubliki Kazakhstan, 2001, No. 5-6, art. 24; No. 17-18, art. 241; No. 21-22, art. 281; 2002, No. 4, art. 33; No. 17, art. 155; 2003, No. 1-2, art. 3; No. 4, art. 25; No. 5, art. 30; No. 11, art. 56, 64, 68; No. 14, art. 109; No. 15, art. 122, 139; No. 18, art. 142; No. 21-22, art. 160; No. 23, art. 171; 2004, No. 6, art. 42; No. 10, art. 55; No. 15, art. 86; No. 17, art. 97; No. 23, art. 139, 140; No. 24, art. 153; 2005, No. 5, art. 5; No. 7-8, art. 19; No. 9, art. 26; No. 13, art. 53; No. 14, art. 58; No. 17-18, art. 72; No. 21-22, art. 86, 87; No. 23, art. 104; 2006, No. 1, art. 5; No. 2, art. 19, 20; No. 3, art. 22; No. 5-6, art. 31; No. 8, art. 45; No. 10, art. 52; No. 11, art. 55; No. 12, art. 72, 77; No. 13, art. 85, 86; No. 15, art. 92, 95; No. 16, art. 98, 102; No. 23, art. 141; 2007, No. 1, art. 4; No. 2, art. 16, 18; No. 3, art. 20, 23; No. 4, art. 28, 33; No. 5-6, art. 40; No. 9, art. 67; No. 10, art. 69):

- delete the words "narcological or toxic" from Article 62, paragraph 10;
- delete the words "for the purpose of selling them" from Article 320.

2. In the *Labour Code of the Republic of Kazakhstan* (15 May 2007) (Vedomosti Parlamenta Respubliki Kazakhstan, 2007, No. 9, art. 65; No. 19, art. 147; No. 20, art. 152):

- in Article 7:
  - o in paragraph 2, add the words "HIV infection" after the word "shortcomings";
  - o add a new paragraph 2-1 as follows: "2-1. Employers are forbidden to conduct HIV-testing as a condition of employment".

3. In the Law of the Republic of Kazakhstan "On Prevention and Treatment of HIV and AIDS" (5 October 1994) (Vedomosti Parlamenta Respubliki Kazakhstan, 1994, No. 16-17, art. 212; Vedomosti Parlamenta Respubliki Kazakhstan, 1999, No. 23, art. 921; 2004, No. 23, art. 142; 2006, No. 15, art. 93):

- in Article 5, paragraph 1, delete the words "individuals retained in the penal system establishments under the judicial bodies of the Republic of Kazakhstan are subject to compulsory confidential medical examination".

4. Regarding President's Decree "On Compulsory Treatment of Alcohol, Drug or Toxic Substances Users", Law No.2184 (7 April 1995) (Vedomosti Parlamenta Respubliki Kazakhstan, 1995, No.3-4, art. 32):

- The President's Decree "On Compulsory Treatment of Alcohol, Drug or Toxic Substances Users", Law No.2184 (7 April 1995) is repealed.

5. In the Law of the Republic of Kazakhstan "On narcotic drugs, psychotropic substances, precursors and countermeasures of their trafficking and abuse" (10 July 1998) (Vedomosti Parlamenta Respubliki Kazakhstan, 1998, No. 17-18, art. 221; 2000, No. 6, art. 141; 2002, No. 10, art. 106; 2004, No. 23, art. 142):

- in the title, delete the words "and abuse";

- in Article 1:
  - o in paragraph (17), delete the word "abuse" and replace it with the word "use";
  - o in paragraph (26), delete the words "abusing drugs or psychotropic substances" and replace them with the words "dependent on drugs, psychotropic substances or their analogues";

- o in paragraph (30), delete the words “or drug abuse”;
  - o in paragraph (35), delete the words “medicine and other substances abuse” and replace them with the words “substance use”;

- in Articles 3 and 4, delete the words “and their abuse”;

- in Article 33:
  - o delete the words “abusing drugs, psychotropic substances and their analogues” and replace them with the words “suffering from drug and toxic substances dependence”;
  - o add the following paragraph: “(36) private use is a dose of specific drug, psychotropic substance and precursor required for daily use by a person using drugs and psychotropic substances”;

- in Table II:
  - o delete para. 21 in Section A;
  - o delete para. 2 in Section B;

- in Table III:
  - o amend Section A with the following entry: “8. METHADONE”
  - o amend Section B with the following entry: “66. BUPRENORPHINE (NORPHINE)”;

6. In the Law of the Republic of Kazakhstan “On Medical and Social Rehabilitation of people with drug dependence” (27 May 2002) (Vedomosti Parlamenta Respubliki Kazakhstan, 2002, No. 10, art.104):

- in Article 1, add the following paragraphs:
  - o “(6) outreach work is a social activity aimed at contacting and raising awareness of individuals or population groups which are at risk of being infected with STI”;
  - o “(7) opioid substitution therapy is a prescription of the opioid substitutive medicine, pharmacologically close to opiate causing a primary addiction, to a person suffering from drug-dependence for achieving a certain treatment purpose, including maintenance therapy”;

- in Article 7, add the following paras:
  - o “(5) Informing the patient about the fact his/her voluntary consent as a prerequisite of treatment, preventive or diagnostic intervention. The mentioned consent must be executed in written form.”
  - o “(6) Information on all medical rehabilitation services is confidential.”

- add a new Article 7-1 as follows:

  “Article 7-1. The order of opioid substitution therapy provision.
  (1) The right for opioid substitution therapy is determined by a prescribing doctor.
  (2) The prescribing doctor is obliged to provide the health care bodies with information on performed deliveries of the allowed opiate as prescribed by the authorized health care body.”

<u>Article 2</u>: This Law becomes effective from the date of its official publication.

KYRGYZSTAN

SUMMARY REPORT AND RECOMMENDATIONS

KYRGYZSTAN: SUMMARY REPORT AND RECOMMENDATIONS

1. BACKGROUND

Early introduction of HIV prevention measures for people who use drugs and prisoners in the Kyrgyz Republic, such as opioid substitution therapy and needle and syringe programmes (including in prisons), demonstrate the country's advanced approach to addressing HIV/AIDS.[816] Nonetheless, there are features of the republic's legislation and policy that persist as barriers impeding effective HIV prevention among these particularly vulnerable groups. According to the analysis prepared by the national expert group, various human rights are not yet fully observed and discrimination against persons living with HIV and various vulnerable groups is widespread. Both positive and problematic aspects of Kyrgyz law and policy are discussed and analysed in detail below, and numerous recommendations for strengthening the country's response to HIV among these populations are presented.

The Ministry of Health reported the total cumulative number of HIV cases as of the end of 2008 was 1479; in 2008, there were 409 new HIV infections recorded. HIV prevalence is less than 1 percent (estimated at roughly 26 cases per 100,000 people). As of 1 August 2007, 66 people in Kyrgyzstan (including 6 women), were receiving antiretroviral (ARV) therapy.[817]

In 2002, the UN Office on Drugs and Crime estimated that 2.3% of the adult population (those between the ages of 15 and 64) were problem users of opioids, and 80% of them used heroin.[818] According to data from the National Narcology Centre of the Ministry of Health, as supplied by UNODC, by 2006 the total cumulative number of people registered as drug users was 7842; the estimated prevalence of injection drug use in the country at that time was 0.76%, with the greatest concentration found in Bishkek, the capital, and in the Osh and Chui provinces. According to the same source, 68% of the total number of people registered as drug users were injecting drugs (5387 people). In 2005, it had been estimated that about 6.7 percent of those in the country with a dependence on narcotic drugs or psychoactive substances are women.[819]

According to the information provided by UNODC, up to 72% of all newly diagnosed HIV infections happen among people who inject drugs. In 2007, the number of HIV cases among people who use drugs was 7.4%. But the coverage of drug users by prevention services is low – at the end of 2007, harm reduction programmes covered approximately 50.4% of the total estimated number of people who need them. Methadone substitution treatment by the end of 2007 was provided to 444 people.[820]

HIV and drug use are concerns in prisons in Kyrgyzstan as well. As of January 2008, 401 people in prison were registered as drug-dependent. UNODC cites the results of several studies, indicating that approximately 35% of the total number of prisoners use drugs, with 50% of this number injecting drugs.[821] As of 1 January 2007, there were 739 people registered in health care facilities and undergoing court-ordered compulsory treatment for drug dependence.

In 2006, the penitentiary system registered 21 cases of viral hepatitis, 237 cases of syphilis, 21 cases of gonorrhoea and 41 new HIV infections. As of 31 December 2007, there were 137 prisoners in the country known to be HIV-positive, 6 of them receiving ARV therapy. In 2008, the Ministry of Health reported the total number of 178 of prisoners with HIV, including 12 prisoners with HIV/tuberculosis co-infection.[822]

816 For some earlier discussion of ways in which Kyrgyzstan has demonstrated regional leadership in responding to injection drug use and related health concerns, see D. Wolfe, Pointing the Way: Harm Reduction in Kyrgyz Republic (Harm Reduction Association of Kyrgyzstan, 2005), online: http://www.soros.org/initiatives/health/focus/ihrd/articles_publications/publications/pointing_20050523 (in English and Russian).

817 Data provided by the national expert group and the Central Asian Regional UNODC office [on file].

818 UNODC, "Kyrgyzstan: General Information", 2008, on file.

819 Statistical information provided by the national expert group [on file].

820 *Ibid*.

821 UNODC, "Kyrgyzstan: General Information", 2008, on file.

822 Data provided by the national expert group [on file].

2. NATIONAL PROGRAMMES AND STRATEGIES

Programme on HIV/AIDS

In Kyrgyzstan, the main objectives of the *"Government Programme for the prevention of the HIV/AIDS epidemic and its social and economic consequences in the Kyrgyz Republic for 2006-2010"* are preventing HIV through initiatives focussed on vulnerable groups of population and providing assistance to those living with HIV/AIDS.[823] Harm reduction is an explicit goal of this Programme, and there are explicit initiatives identified in relation to people who use drugs and for prisoners. In addition, the national AIDS Programme makes explicit reference to the need to advance the rights of people living with or vulnerable to HIV.

Strategy 2.2 of the Programme ("Reduced vulnerability to HIV/AIDS of injecting drug users and other co-dependent persons [созависимые лица]") envisages *increased coverage of harm reduction programmes for injecting drug users*, through the following activities:

- undertaking a situation analysis and assessing the needs of injecting drug users and drug-dependent persons in relation to HIV/AIDS;
- creating new, and developing existing, programmes of syringe exchange in all regions of the country, by both governmental and non-governmental organizations, as well as strengthening the capacity of people who use drugs to run these programmes;
- creating incentives for civil society, grassroots organizations, and organisations of people who use drugs and to organize partnerships to reach more than 60% of the target group with services;
- introducing substitution therapy programmes;
- assisting in the development and expansion of the network of harm reduction programmes with the participation of the state, international and non-governmental organizations.

The national AIDS programme also calls for expanding harm reduction programmes in penitentiary facilities. Strategy 2.3 ("Reduced vulnerability to HIV/AIDS among prisoners and the personnel of the penitentiary establishments") deals directly with the *expansion of programmes of harm reduction in penitentiary establishments* and includes the following activities:

- improving the infrastructure and activities of syringes exchange programmes in penitentiaries;
- introducing substitution therapy programme for prisoners who are dependent on drugs;
- training of staff in the penitentiary facilities in providing harm reduction services;
- delivering regular motivational trainings for prisoners on safe behaviours and abstaining from drug use in all penitentiary institutions;
- expanding existing, and introducing new, effective programmes of rehabilitation for people who use drugs; and
- implementing measures to develop safer sex skills and supplying condoms.

According to the Kyrgyz national expert group, currently the participation of people living with HIV (PLHIV) or people affected by the epidemic in HIV prevention programmes remains insignificant. The national expert group has also reported that often the rights of persons belonging to vulnerable groups are infringed. However, the national AIDS Programme includes the empowerment of people living with HIV as a key strategy (Strategy 2.7), and includes the objectives of: developing the community of PLHIV and people affected by HIV/AIDS to improve quality of life; promoting tolerant attitudes toward PLHIV; establishing interaction with heads of governmental and non-governmental organizations to overcome stigma and discrimination; and increasing the participation of PLHIV in all stages of developing, implementing and monitoring of State programmes on HIV/AIDS.[824] To this end, the following activities are planned:

823 *Government Program for the prevention of the HIV/AIDS epidemic and its social and economic consequences in the Kyrgyz Republic for 2006-2010,* [Государственная программа по предупреждению эпидемии ВИЧ/СПИДа и ее социально-экономические последствия в Кыргызской Республике на 2006-2010 годы], approved by Government of the Kyrgyz Republic, Order No. 498 (6 July 2006).

824 One of the declared main principles of state policy in the area of health protection is the active participation of the population and public organizations in addressing problems of health protection: *Law "On health protection in the Kyrgyz Republic"* [Об охране здоровья граждан в Кыргызской Республике], Law No. 6 (9 January 2005), Article 4 [hereinafter *Law "On health protection"*].

- providing support to groups of PLHIV by training and increasing leadership potential of groups and individual representatives of the PLHIV community;
- mobilizing financial resources of the PLHIV community; and
- building its capacity to protect rights and interests of its members.

Finally, it is worth noting Strategy 3.3 of the national AIDS programme ("Programmes of legal support to persons living with HIV/AIDS and representatives of vulnerable groups of the population"), which has the declared objective of enhanced legal security of PLHIV and representatives of vulnerable groups. Activities in this area are to include:

- providing free and accessible legal aid services for PLHIV and representatives of vulnerable groups;
- monitoring and assessing the human rights needs of PLHIV and representatives of vulnerable groups; and
- promoting tolerant attitudes toward PLHIV and representatives of vulnerable groups through educational institutes, media, cultural and religious institutions, legal system and state policy.

As stated by the *Law "On HIV/AIDS in the Kyrgyz Republic"*, financing for targeted HIV/AIDS programmes comes from: (a) the national and local budgets of the Kyrgyz Republic; (b) loans, grants and trust funds; (c) medical insurance; and (d) other sources.[825] According to the national expert group, insufficient funds have been allocated for implementing the national AIDS programme. For example, the *Law "On the national budget of the Kyrgyz Republic for 2007"* did not contain funding for HIV prevention.[826] Besides, the social and economic situation in Kyrgyzstan allows little room for funding HIV prevention efforts from the state budget; the majority of funding for HIV prevention comes from external sources. According to the national expert group, an effective implementation of the national AIDS programme requires more funding from the national budget and its careful allocation. In addition, there is a need to define more clearly the responsibility of various governmental bodies for implementing the programme and ensuring its effectiveness.

The government has introduced other measures to address other diseases of relevance to PLHIV and vulnerable populations such as people who use drugs and prisoners. For example, PLHIV and many people who use drugs and prisoners are particularly vulnerable to tuberculosis. The *National Programme on Tuberculosis-III for 2006-2010* provides for various initiatives aimed at prevention, early detection and treatment of tuberculosis among prisoners in correctional facilities, including ensuring 100 percent coverage among prisoners with tuberculosis by directly-observed therapy (short-course) (DOTS). In addition, the programme calls for measures to improve sanitary, housing and food conditions in prisons for prisoners with tuberculosis.[827] The Ministry of Health has also issued an important order on viral hepatitis prevention, yet it contains no provisions for hepatitis prevention among injection drug users, even though they are the primary group infected and at risk.[828]

Programme on drugs

At this writing, Kyrgyzstan is implementing the "*Concept against drug dependence and drug trafficking"* and the "*National Programme of the Kyrgyz Republic against drug dependence and drug trafficking for the period until 2010*".[829] The Concept and the National Programme contain elements of prevention of drug (mis)use, treatment of drug dependence, law enforcement measures and certain elements of harm reduction. Under the Concept, the Drug Control Agency of the Kyrgyz Republic has responsibility for coordinating and supervising efforts to counteract both narcotic addiction and drug trafficking. The Concept also mentions that non-governmental organizations must have an opportunity to monitor implementation of the programme, thus providing at least some opportunity for possible oversight of law enforcement by civil society.

825 Law "*On HIV/AIDS in the Kyrgyz Republic"* [О ВИЧ/СПИДе в Кыргызской Республике], Law No. 149 (13 August 2005) [hereinafter *Law "On HIV/AIDS"*].

826 *Law "On the National Budget of the Kyrgyz Republic for 2007"* (5 April 2007).

827 *National Program on Tuberculosis-III in 2006-2010*, Government of the Kyrgyz Republic, Order No. 331 (6 May 2006).

828 Ministry of Health, Order "On measures to reduce prevalence of viral hepatitis" [О мерах по снижению заболеваемости вирусными гепатитами в республике], Order No. 222 (15 June 1999).

829 *Concept of counteraction of drug dependence and drug trafficking* [Концепция противодействия распространению наркомании и незаконному обороту наркотиков] and the *National Program of the Kyrgyz Republic to counteract drug dependence and drug trafficking for the period until 2010* [Национальная программа Кыргызской Республики по противодействию наркомании и незаконному обороту наркотиков на период до 2010 года], both approved by the Decree of the President of the Kyrgyz Republic, Decree No. 445 (22 December 2004).

3. ADMINISTRATIVE AND CRIMINAL LAW PROVISIONS ON DRUGS

The *Law "On narcotic drugs, psychotropic substances and precursors"* defines "illicit drug use" as "drug use without medical prescription".[830] Narcotic drugs, psychotropic substances and precursors may be used for medical and scientific purposes.[831] The Law prohibits any form of advertising of narcotic drugs, psychotropic substances and precursors,[832] and growing plans containing narcotic substances.[833] However, as in other legal systems of the region, the law does not define liability, which is established in administrative and criminal codes. The Law also has detailed provisions on drug testing and compulsory drug dependence treatment, which are highlighted below (in Section 4).

The Government of Kyrgyzstan adopts a list of narcotic drugs and psychotropic substances that are prohibited or controlled in Kyrgyzstan, based on recommendations of the Drug Control Agency. The document also establishes the quantity of narcotic drugs and psychotropic substances sufficient for classifying offences as either administrative offences or criminal offences. The Government approved the current quantities of narcotic drugs and psychotropic substances in November 2007.[834] According to the information and analysis provided by the national expert group of Kyrgyzstan, this document defines amounts of illegal drugs as including whatever fillers (e.g., flour) they might contain, as opposed to pure amounts of illegal drugs. According to the national expert group, this provision should be reformed so that any administrative or criminal liability is based solely on pure amounts of illicit drugs.

Administrative offences

The *Code of the Republic of Kyrgyzstan on Administrative Responsibility* defines the following as administrative offences:[835]

- The "use of narcotics or psychotropic substances, the consumption of alcohol in the streets, stadiums, parks, in public transport and in other public places, or appearing in public in a state of intoxication that offends human dignity and social morality" is punishable by a fine.[836] A repeat offence within one year of a first offence is punishable with a heavier fine. While the drafting is ambiguous, it appears that this article creates three distinct administrative offences: a) the mere use of narcotics or psychotropic substances; b) drinking alcohol in public; and c) appearance in public in the condition of intoxication that offends human dignity and social morality.

- Illegal possession, transportation or transfer of narcotics or psychotropic substances *without an intention to sell* and in a "small quantity" [небольшие размеры] is punishable by a fine or administrative arrest for up to five days.[837] A repeat offence within a year is punishable by administrative arrest for a term of five to fifteen days.

- Infringement of the prescribed rules governing the manufacture and legal circulation of narcotics is punishable by a fine.[838]

- Cultivating prohibited narcotics in a "small quantity" [небольшие размеры], and failure to take measures to destroy wild-growing narcotic plants by persons responsible for land plots, are both punishable by a fine.[839]

830 *Law "On narcotic drugs, psychotropic substances and precursors"*, Law No. 66 (22 May 1998).

831 *Ibid*., Article 24.

832 *Ibid*., Article 9.

833 *Ibid*., Article 25.

834 Government of the Kyrgyz Republic, Order "On narcotic drugs, psychotropic substances and precursors, controlled in the Republic of Kyrgyzstan", No. 543 (9 November 2007).

835 The minimum age for administrative liability is 16: *Administrative Code,* Article 15.

836 *Code of the Kyrgyz Republic on Administrative Responsibility* [Об административной ответственности], No. 114, (4 August 1998), Article 366 [hereinafter "*Administrative Code*"].

837 *Ibid*., Article 91-2.

838 *Administrative Code,* Article 91-3.

839 *Administrative Code,* Article 191.

Being intoxicated by alcohol or a narcotic or psychotropic substance while committing an administrative offence is an aggravating circumstance that can result in a harsher penalty.[840]

The national expert group's analysis flags an additional concern. The *Administrative Code* (Article 366) prohibits "*use of narcotics or psychotropic substances, drinking of alcohol or appearance in the public in the condition of intoxication offending human dignity*". In light of identified concerns about corruption in the law-enforcement system, the concern is that such a provision creates additional opportunities for unscrupulous police to target people for detention and threatened charges merely for using drugs or for being under the influence of alcohol or drugs in a public place. The national expert group has also identified the concern that such widespread penalization of drug users undermines the effective realization of harm reduction programmes and HIV prevention in the country, creating additional barriers to these services by penalizing people merely for using drugs, a behaviour that needs to be addressed via health services rather than through criminal prosecution and penalties.

Criminal offences

In relation to prohibited drugs, the Kyrgyz *Criminal Code*[841] distinguishes between activities committed "with intention to sell" and "without intention to sell". (The law does not contain the concept of possessing drugs "for personal use".) The following are criminal offences under current Kyrgyz law:[842]

- Illegally manufacturing, acquiring, possessing, transporting or mailing narcotic drugs or psychotropic substances in a "small quantity" [небольшие размеры], when committed *without an intention to sell* and after an administrative fine has been imposed for the same offence, is punishable by "communal works",[843] a fine, the restriction of freedom for up to two years or imprisonment for up to two years.[844]

- Illegally manufacturing [изготовление], acquiring, possessing, transporting or mailing any quantity of narcotic drugs or psychotropic substances *with an intention to sell*, or the illegal production [производство] or sale of any quantity of narcotic drugs, psychotropic substances, or their analogues or precursors, is punishable by imprisonment for a term of four to eight years. An offence that involves a "large quantity" [крупные размеры] attracts a more serious penalty, such as eight to twenty years' imprisonment, and the confiscation of property.[845]

- "Inducement" to consume narcotic drugs or psychotropic substances is punishable by "corrective works"[846] for up to two years, restriction of freedom for up to three years or imprisonment for up to two years. If committed in conspiracy by a group of persons, this same offence is punishable by corrective works for up to three years, restriction of freedom for up to five years or imprisonment for up to five years.[847]

- The cultivation of narcotic plants in a "small quantity" [небольшие размеры], committed again within a year after receiving an administrative penalty, is punishable by a fine, corrective works for up to three years or imprisonment from two to five years, with or without the additional confiscation of property.[848]

840 *Administrative Code*, Article 43.

841 *Criminal Code of the Kyrgyz Republic*, Law No. 68 (1 October 1997) [hereinafter "*Criminal Code*"].

842 The minimum age for general criminal liability is 16 years old. However, for certain "grave" crimes — which includes not only such crimes as murder but also the illegal manufacturing, purchase, possession, transportation or mailing of narcotic drugs with the purpose of sale, or the actual sale, of drugs (Article 247), and stealing or extortion of narcotic drugs (Article 248) — the minimum age for criminal liability is 14: *Criminal Code*, Article 18.

843 "Communal work" [общественные работы] (i.e., community service) is an alternative to incarceration, and is performed while the sentenced person continues his or her studies, employment, etc., during free time, without remuneration. The duration of communal work is from 40 to 100 hours. See: *Criminal Code*, Article 43.

844 *Criminal Code*, Article 246.

845 *Criminal Code*, Article 247.

846 "Corrective work" [исправительные работы] is a more serious punishment than "communal work", also used as an alternative to incarceration when the person constitutes no danger to society, for "insignificant" and "less serious" offences [преступления небольшой тяжести и менее тяжкие преступления]. Corrective work is performed in the region of person's residence, and could be performed at one's regular place of employment. A portion (usually 5–20%) of the person's wage during the period of corrective work is directed to the state budget. The duration of corrective work is from 3 month to 3 years. See: *Criminal Code*, Article 46-2.

847 *Criminal Code*, Article 249.

848 *Criminal Code*, Article 250.

- Organizing or maintaining a site for the consumption of narcotic drugs, or allowing premises to be used for this purpose, is punishable by corrective works for up to two years, restriction of freedom for up to three years or imprisonment for up to three years, with or without the additional confiscation of property. If committed in conspiracy by a group of persons this same offence is punishable by restriction of freedom for three to five years or imprisonment for up to five years.[849]

Being intoxicated by alcohol or a narcotic or psychotropic substance while committing a criminal offence is an aggravating circumstance that can result in a harsher penalty.[850]

According to the *Criminal Code* (Article 42), non-custodial sentences include the following options: 1) communal works; 2) fine; 3) threefold *ayip* (compensation of damages);[851] 4) deprivation of the right to occupy certain posts or be engaged in certain activities; 5) public apology with compensation of damages; 6) corrective works; and 7) restriction of freedom. Fines, a public apology accompanied by compensation of damages, and the deprivation of the right to occupy certain posts or to be engaged in certain activities, all may be applied in addition to any other kind of penalty. Instead of sentencing a person to imprisonment, the court may give an offender a conditional sentence, taking into account the personality of an offender and the danger posed by the offence.[852]

In 2007, Kyrgyzstan implemented reforms aimed at "humanizing" its drug laws. Specifically, it took steps to "partially decriminalize" certain activities involving drugs *without an intention to sell*.[853] However, as noted by the national expert group, the full decriminalization of drug *use* and of *possession without intention to sell* has not yet been achieved. As a result of the 2007 amendments, the *Criminal Code* still prohibits manufacturing, acquiring, possessing, transporting or mailing narcotic drugs or psychotropic substances in a "small quantity" [небольшие размеры], even without an intention to sell, if committed within a year after receiving an administrative fine for the same offence and by a person who earlier committed *any* offence connected with drugs. In other words, a first offence is but administrative in nature; a repeat offence is a crime — any decriminalization is of a very limited nature, and given the nature of drug dependence as a chronic, relapsing condition into drug use (and hence possession), Kyrgyz law still effectively criminalizes many people with drug dependence. Furthermore, concern remains with the very restrictive approach to defining a "small quantity" of drugs; this, too, requires attention in order effectively to decriminalize people who use drugs (including those with drug dependence). The national expert group concluded that the defined quantities of narcotic substances and psychotropic substances currently in effect in Kyrgyzstan do not meet modern realities and recommended revising these definitions with a view to decriminalizing the acquisition and possession of narcotic drugs and psychotropic substances *without an intention to sell* in quantities that reflect realistically the use of such drugs by individuals, particularly by people with dependence.

Needle and syringe programmes: legal issues

Neither the *Administrative Code* nor the *Criminal Code* penalize the possession of accessories for drug use, including syringes and needles. The National Drug Control Commission under the auspices of the Government of Kyrgyzstan is responsible for the control of tools and equipment that can be used for the illegal manufacturing of narcotics, but fortunately, needles and syringes are not included among the definition of "tools and equipment."[854]

However, the national expert group has also observed that there are no legislative provisions that explicitly exclude harm reduction programmes from the sphere of criminal and administrative law, and has noted two issues in particular that warrant further attention.

First, criminal and administrative liability is possible based on a residual quantity of drugs in a syringe or on other drug use equipment, with fillers included in the determining the quantity. As noted by the national expert group, the Government Order defining different quantities of drugs for administrative and criminal law purposes establishes only the *upper* limit of the "small quantity" [небольшие размеры] of various narcotic drugs and psychotropic substances, and does not define the lower limit of this category to reflect minimal amounts. In other words, the legal category of "small" quantity" includes *any* quantity, however minimal. For example, the residual quantity of drug in a syringe could potentially be a basis for a prosecution. The expert group has noted that this potentially undermines the use of harm reduction programmes such as needle and syringe programmes, including the safe return and disposal of used injection equipment that carries residual amounts of prohibited drugs, since being found in possession of such an item can then become the basis for a charge.

Second, the national expert group noted a concern about the *Criminal Code* provision on "incitement" to drug use. Theoretically, outreach workers, peer consultants, and staff of harm reduction programmes such as needle exchanges could run afoul of this provision if they are treated as "inciting" someone to drug use by providing sterile drug-use equipment or education about how to use drugs in ways that minimize the risk of HIV infection or other harms.

On an encouraging note, however, it is also worth noting that the Ministry of Internal Affairs has issued official instructions to law enforcement personnel stating that:

> With a view toward HIV prevention, employees of the regional office of the Ministry of Internal Affairs (OVD) shall cooperate with governmental and non-governmental organizations running harm reduction programmes (e.g., needle and syringe exchange, methadone programmes), and shall inform people who use drugs and their relatives about harm reduction programmes, telephone hotlines, self-help groups and anonymous groups of people with drug dependence.[855]

Compulsory drug testing by law enforcement authorities

The law provides several bases on which police, investigative authorities and courts may subject a person to drug testing without his or her consent. According to the information reported by the national expert group, involuntary testing may be conducted:

- based on the grounds provided by the *Administrative Code* (i.e., consumption of alcohol or drugs in public place, driving vehicles in a condition of intoxication);
- in the case of a car/transportation accident (testing of those involved in the accident);
- in connection with the commission of a criminal offence, or even simple suspicion of having committed such an offence.

Drug testing is performed upon request by the police; a full medical examination (to determine drug dependence) is done under the supervision of a narcologist of official public health care bodies of Kyrgyzstan.[856] Refusal to undergo testing or medical examination leads to compulsory referral to a narcological facility by police, and compulsory testing/ examination without consent.

High risk groups: criminal and administrative law issues

Human rights abuses against sex workers

Sex work *per se* is not prohibited in Kyrgyzstan, which is a positive feature. The *Criminal Code* does pro-

849 *Criminal Code,* Article 252.

850 *Criminal Code,* Article 55(16).

851 *Criminal Code,* Article 45: "Threefold *ayip* is a compensation imposed by a court as triple the amount of the inflicted damage in monetary or natural form. Two parts of the threefold *ayip* are payable to the victim to compensate for material and mental harm, and the third part is collected by the state. This punishment is applied to persons convicted of a deliberate crime for the first time."

852 *Criminal Code,* Article 63.

853 *Law* "*On amending the Criminal Code of the Kyrgyz Republic*", Law No. 91 (25 June 2007).

854 "The list of tools and equipment under special control and used in illegal manufacturing of narcotic, psychotropic or strong substances" [Список инструментов и оборудования, находящихся под специальным контролем и используемых при незаконном изготовлении наркотических средств, психотропных или сильнодействующих веществ] approved by State Drug Control Commission under the auspices of the Government of Kyrgyzstan, Order No. 3 (4 May 2000).

855 Ministry of Internal Affairs, "Instruction for employees of the law-enforcement bodies for prevention of HIV among vulnerable groups", Order No. 389 (20 August 2003).

856 The procedure for referral for drug testing is regulated by the *Law* "*On narcotic drugs, psychotropic substances and precursors*" [О наркотических средствах, психотропных веществах и прекурсорах], Law No. 66 (22 May 1998), and by Government Regulation "On the procedure of physical examination to determine intoxication or the fact of using psychoactive substances in the Kyrgyz Republic" [Положение о порядке проведения медицинского освидетельствования на предмет установления состояния опьянения или факта употребления психоактивных веществ в Кыргызской Республике], Regulation No. 137 (2 May 2001); Regulation "On the conduct of the expert judicial narcological assessment in the Kyrgyz Republic" [Положение о производстве судебно-наркологической экспертизы в Кыргызской Республике], Regulation No. 137 (2 May 2001).

hibit "involving another in sex work using violence, threats and coercion"[857] and "organising and maintaining brothels for prostitution"[858] — the former provision is important to protect human rights, but the latter provision, depending on how it is interpreted and applied, could pose a problem for sex workers' ability to control their own working conditions and better protect their own safety, including with respect to HIV and STI prevention. The national expert group has noted that police abuse and harassment of sex workers remain of concern. According to the group, it is common for police to arrest and charge sex workers for such things as "debauchery", violation of public order, disobeying police officers or the absence of identification documents. The national expert group has also noted that there is evidence of forced testing for sexually transmitted infections (STIs), which could then lead to administrative charges for avoiding STI treatment. (The human rights concerns of coercive testing and treatment more generally are discussed further in Section 4 below.) Harassment of sex workers contributes to their further stigmatization and marginalization, putting them at greater risk of human rights abuses and exacerbating vulnerability to HIV. It is recommended to conduct educational trainings and seminars with law enforcement personnel, aimed at ceasing this practice.

STI and HIV exposure and transmission
The following are offences under the *Criminal Code*:

- Knowingly *exposing* someone to HIV infection is punishable by correctional works, limitation of freedom or imprisonment, all for up to one year.[859] HIV *transmission* by a person who was aware of his or her infection is punishable by limitation of freedom for up to five years or imprisonment for up to five years, and transmission to two or more people or to a minor is punishable by imprisonment for up to five years.[860] (Note that a person is not liable for either offence if he or she disclosed his or her HIV infection and the partner agreed to the risk behaviour.)
- Transmission of other "venereal disease" by someone who was aware of his or her infection is punishable with a fine, limitation of freedom for up to three years or imprisonment for up to three years. A second or subsequent offence, or transmission to two or more people or to a minor, is punishable by imprisonment for up to five years.[861]
- HIV transmission as a result of negligent performance of professional duties by a health care professional is punishable by limitation of freedom for up to five years or imprisonment for up to five years with a prohibition to hold certain positions for up to three years.[862]

Having a specific criminal offence singling out HIV exposure and negligent HIV and STI transmission runs contrary to internationally recommended policy, in part because it stigmatizes people living with HIV, and people vulnerable to it, and may create a further disincentive for HIV testing and an additional barrier to access to health services. The *International Guidelines on HIV/AIDS and Human Rights* recommend against such an approach: criminal legislation should not include specific offences regarding HIV transmission or exposure, and the scope of applying criminal law should be limited to those cases where someone acts with malicious intent to transmit HIV and does in fact transmit the virus.[863]

857 *Criminal Code*, Article 260.

858 *Criminal Code*, Article 261.

859 Ibid., Article 117(1).

860 Ibid., Article 117(2) and (3).

861 Ibid., Article 118.

862 Ibid., Article 117(4).

863 Joint United Nations Programme on HIV/AIDS & Office of the High Commissioner for Human Rights, *International Guidelines on HIV/AIDS and Human Rights,* Guideline 4, para. 21(a); UNAIDS, *Policy Brief: Criminalization of HIV Transmission* (2008).

4. HEATH SYSTEM AND SERVICES

The right to health is guaranteed in the *Constitution of the Kyrgyz Republic*: "citizens of the Kyrgyz Republic have the right to health protection."[864] In addition, the *Law "On health protection in the Kyrgyz Republic"*[865] defines the right of citizens to health protection and establishes that health care is provided through (a) granting everybody equal possibilities in realization of the right to receive medical, sanitary and social assistance; and (b) granting medical and sanitary assistance throughout the entire country.[866]

In Kyrgyzstan, there is no general free access to medical services for the population. Free of charge health care services and medications are provided only within the context of emergency medical care.[867] In other cases, health care is provided under obligatory medical insurance.[868] According to the *Law "On medical insurance of citizens in the Kyrgyz Republic"*, persons who are not covered by the system of obligatory medical insurance pay for medical, preventive, rehabilitation and other health services on their own. If they are officially insured under the obligatory health care insurance, unemployed persons have the right to receive some free health care services.[869]

Rules and regulations attach citizens to public health services based on territorial location.[870] The national expert group has noted that these rules were designed so as to give patients a free choice of family doctors, and to ensure availability and guarantees of qualitative primary medical assistance. Homeless people can count only on receiving emergency and urgent health care assistance free of charge.

Medication is provided according to the Programme of State Guarantees, based on the "List of Essential Medicines and Medical Products" approved by the Government of Kyrgyzstan, with funds allocated from the state budget and obligatory medical insurance.[871] The scope and quantities of medicines and medical products provided by the state may be expanded with funding from municipalities, local budgets and international aid.

4A. DRUG DEPENDENCE PREVENTION AND TREATMENT

According to the analysis performed by the national expert group currently, Kyrgyzstan has an inadequate legal framework for the prevention and treatment of drug dependence. The *Law "On narcotics, psychotropic substances and precursors"* focuses almost exclusively on drug control, and does not address problems of prevention and treatment of drug dependence. Only Article 38 of the Law mentions voluntary treatment, in general terms.

Treatment of drug dependence may be carried out in both state and private health care facilities.[872] Drug dependence treatment is also conducted in medical institutions of the penitentiary system, private narcological clinics and in a number of non-governmental organizations. Treatment in a narcological hospital is conducted based on co-payment by the patient: the Programme of State Guarantees covers part of the

864 *Constitution of the Kyrgyz Republic* (5 May 1993), amended by the *Law "On the new edition of the Constitution of the Kyrgyz Republic"*, Law No. 2 (15 January 2007), Article 34(1).

865 *Law "On health protection in the Kyrgyz Republic"*, Law No. 6 (9 January 2005).

866 Ibid., Article 61.

867 According to the Program of State Guarantees, all patients who arrived in hospitals in emergency situations are to receive emergency medical care free of charge.

868 *Law "On medical insurance of citizens in the Kyrgyz Republic"* [О медицинском страховании граждан], Law No. 112 (18 October 1999). The procedure of issuing and acquiring the policy of obligatory medical insurance is regulated by the Statute on the Policy of Obligatory Medical Insurance, approved by the Ministry of Health, Order No. 196 (15 June 2000), and the Statute on the policy of obligatory medical insurance for the citizens the Kyrgyz Republic who make payments to the obligatory medical insurance, approved by Government of the Kyrgyz Republic, Order No. 675 (31 October 2001).

869 *Law "On medical insurance of citizens"*, Articles 8 and 9.

870 Ministry of Health, "Temporary rules for registration of the population to groups of family doctors in the Chui, Issyk-Kul, Jalal-Abad provinces and Bishkek", Order No. 312 (21 July 2003).

871 Government of the Kyrgyz Republic, "List of the essential medical products of the Kyrgyz Republic" [Перечень жизненно важных лекарственных средств и изделий медицинского назначения], Order No. 759 (31 October 2006).

872 *Law "On narcotic drugs, psychotropic substances and precursors"*, Law No. 66 (22 May 1998).

cost and patients must pay any difference.[873] Methods of treatment include detoxification programmes, medical and psychological rehabilitation and opioid substitution treatment. Narcological facilities carrying out detoxification operate in "closed doors" settings, with restriction of access of visitors and prohibition of patients going out of the facility without health care personnel or relatives, with the goal of preventing access to alcohol, drugs or other psychoactive substances.[874]

Since 2004, the National Centre of Narcology has been using psychotherapeutic and rehabilitation techniques such as motivational counselling and training, group psychotherapy, socio-psychological trainings and "personal growth" groups.[875] There is a rehabilitational department with psychotherapeutic and psychological services, rehabilitational environment, employment therapy and work with family members of patients. Narcological assistance includes subsequent care and rehabilitation of drug-dependent persons after treatment.

Registration of people who use drugs and drug dependent people

The National Centre of Narcology ensures registration of people with narcological disorders, a diagnosis established by psychiatrists or narcologists.

Removing someone from the registry requires a decision of the medical advisory commission and is based on the following grounds: death of the patient; departure of the patient from the country for permanent residence elsewhere; or recovery of the patient. In the case of dependence, "recovery" is defined as proven remission for at least three years; in the case of psychotic disorders without signs of drug dependence, "recovery" is defined as the absence of a relapse to drug use for one year.[876]

According to the national expert group, patient's medical history cards state the date a person was removed from the registry and on what basis. This information is stored separately from currently registered persons and is used for statistical purposes only. After the end of the calendar year, the cards are archived in the medical facility. All these details are "medical secrets", the confidentiality of which is protected by law.[877] The disclosure of data about patients and their diagnoses to governmental and non-governmental organizations that do not have powers of judicial and investigatory bodies is prohibited.[878] According to the information provided by the national expert group, health care workers must share confidential information about patients receiving drug dependence treatment only upon official request by the police, investigative bodies, the public prosecutor or a court. However, they are not obliged to report to law enforcement authorities those patients who seek drug dependence treatment or overdose treatment. On this specific point, Kyrgyz law is more progressive than the legislation of some other countries of the region. There is room for further improvement, since failing to protect fully the confidentiality of patients receiving treatment for drug dependence can still create a disincentive for people to seek health services if this may result in investigation and possible prosecution by law enforcement authorities.

Opioid substitution therapy

Kyrgyzstan approved the use of opioid substitution therapy (OST) in 2001, becoming one of the first countries in the Commonwealth of Independent States to do so.[879] In 2002, pilot programmes providing methadone maintenance therapy for patients with opioid dependence began at the National Centre of Narcology (in Bishkek) and the Osh regional narcological facility were introduced. In Bishkek, the programme was financed by the "Soros-Kyrgyzstan" Foundation and the Open Society Institute; in Osh it was funded by the United Nations Development Programme.[880]

873 The order for co-funding is defined by the Statute on Co-Funding for the medical services provided by the organizations of public health services working in system of the 'Uniform Payer', (24 August 2007) № 363.

874 Ministry of Health, "Instruction on the order and conditions of medical assistance in the narcological area" [О мерах по дальнейшему развитию и совершенствованию наркологической помощи в Кыргызской Республике], Order No. 65 (12 February 2004).

875 Ministry of Health, Order "On establishing departments of medical and psychological rehabilitation on the basis of the National Centre of Narcology," Order No. 16 (16 January 2006) (within the scope of UNODC Project F75).

876 Regulation "On rules and procedure for registration and account of narcological disorder in the official bodies of public health services of the Kyrgyz Republic" [Положиение о правилах и порядке регистрации и учета наркологических расстройств в государственных учреждениях здрваоохранения Кыргызской Республики], (21 January 2002) No. 16.

877 Ibid.

878 Ibid., and also *Law "On health protection in the Kyrgyz Republic"* [Об охране здоровья граждан], Law No 6 (9 January 2005).

879 Order "On conditions and order of carrying out substitution therapy with methadone for people with drug dependence in the Kyrgyz Republic" [Об условиях и порядке проведения заместительной терапии лицам с наркотической зависимостью в Кыргызской Республике], Order No. 41 (15 February 2001).

880 For more, see Wolfe, *Pointing the Way: Harm Reduction in Kyrgyz Republic*.

Originally, the programmes started on a pilot basis and only in specialized narcological facilities. However, they have since been extended and OST is now implemented in subsidiaries of the original facilities, which are specialized hospitals providing in- and out-patient care (e.g., two additional programmes in the family medicine centres in Bishkek have been opened, funded by the Global Fund to Fight AIDS, Tuberculosis and Malaria).[881] By the end of 2007, eight facilities were providing OST. Although first authorized in 2005, OST programmes were introduced in the penitentiary system in 2008.[882]

OST using methadone is provided in specialized narcological facilities as long-term maintenance treatment; in some cases, it may also be used for short-term detoxification. Methadone is included in the list of essential medicines in the Kyrgyz Republic.[883] According to regulations, OST is prescribed for the following purposes:

- improving the somatic and mental condition of patients with opium/opioid dependence and the timely detection and treatment of accompanying diseases;
- preventing HIV and hepatitis B and C infection among people who use drugs, and preventing and treating complications caused by intravenous drug use;
- improving the social adaptation and social reintegration of people with drug dependence;
- providing pre- and post-natal health care services to pregnant women who use drugs;
- assisting people with drug dependence and HIV in stopping injection drug use.[884]

Selecting patients for OST programmes is the responsibility of a special advisory committee created within a medical institution by order of its chief physician. The committee considers such factors as:

- drug dependence on opioids;
- age (a minimum age of 18 is required);
- repeated in-patient drug dependence treatment in narcological facilities (at least twice);
- legal capacity (the ability to understand and be responsible for one's actions);
- HIV infection;
- pregnancy; and
- belonging to a risk group (e.g., sex workers).[885]

The advisory committee should also consider the following requirements: the patient's dependence is exclusively on opioids (and patients with poly-drug dependence are not eligible); the patient's expression of a voluntary desire to participate in the programme; the patient's consent of the patient to stay in a particular city/town for not less than one year; and the patient's consent to the non-anonymous, albeit confidential, nature of his or her participation in the programme.

A patient may be expelled from the programme on the following grounds:

- continued use of illicit drugs, despite warnings of the programme staff (determined by drug testing of blood or urine);[886]

881 Ministry of Health and Drug Control Agency, Order "On further development of programs of substitution therapy for opioid addiction in the Kyrgyz Republic" [О дальнейшем развитии программ заместительной терапии при опиоидной зависимости в Кыргызской Республике], Joint Order No. 227/60 (3 May 2006 and 13 May 2006); and Ministry of Health and Drug Control Agency, Order "On expansion of the program of substitution supporting therapy with methadone for opiod dependence on the territory of Bishkek and Chuy region" [О расширении программы заместительной поддерживающей терапии метадоном при опиоидной зависимости на территории г.Бишкек и Чуйской области], Joint Order No. 56/15 (8 February 2007 and 14 February 2007).

882 Ministry of Health and Ministry of Justice, "On a pilot program 'Methadone opioid Substitution therapy for people with drug dependence in the penitentiary institutions of the Kyrgyz Republic'" ["О пилотной программе «Заместительная терапия метадоном лицам с наркотической зависимостью в учреждениях ГУИН Министерства юстиции Кыргызской Республики»], Joint Order No. 13/7.

883 Government of the Kyrgyz Republic, "List of the essential medical products of the Kyrgyz Republic", Order No. 759 (31 October 2006).

884 Ministry of Health, Order "On conditions and procedures of substitution therapy with methadone in the Kyrgyz Republic" [Об условиях и порядке проведения заместительной терапии метадоном в Кыргызской Республике], Order No. 71 (13 March 2001).

885 OST is regulated under the following instruments: Ministry of Health, Order "On conditions and procedure of substitution therapy for persons with narcotic addiction in the Kyrgyz Republic", Order No. 41 (15 February 2001) and the Program of "Substitution therapy with methadone in Bishkek", approved by this same Order; "Provision on rules and procedures for registration and account of narcological disorders in official bodies of the public health services of the Kyrgyz Republic", approved by Ministry of Health, Order No. 16 (21 January 2002); "Concept of counteraction to distribution of narcotic addiction and drug trafficking in the Kyrgyz Republic", approved by the President of the Kyrgyz Republic, Decree No. 445 (22 December 2004).

886 During outpatient substitution treatment, patients are obliged to undergo testing for use of psychoactive substances, in order to establish the effectiveness of treatment and to detect any concurrent drug use: Ministry of Health, Order No. 41.

- regular alcohol abuse with signs of alcohol dependence;
- not complying with regularly scheduled visits to the programme, refusal to cooperate with a narcologist or psychologist, or refusal to undergo physical examination;
- commission of a criminal offence and detention pending trial (in which case, a patient may be eligible to receive OST in the penitentiary facilities);
- selling methadone or illicit drugs; and
- aggression toward programme staff.

Each OST patient receives an individual plan of diagnostics and treatment, undergoes testing for hepatitis, HIV, STI and other diseases, and receives treatment of complications and accompanying diseases. Every three months, the facility's advisory committee assesses the effectiveness of the therapy and develops treatment plan. OST can be carried out on an inpatient or outpatient basis. When OST is provided in outpatient facilities, patients must visit the medical institution daily and receive methadone under the supervision of programme staff. In special cases (e.g., in case of illness of the patient demanding home-based treatment, confirmed by doctor's certificate), the advisory committee may authorize that methadone be dispensed to a family member in a quantity not exceeding two daily doses.[887]

In cases when patients receiving OST are hospitalized in other medical and rehabilitation institutions, OST programme administrators are obliged to co-ordinate the procedure of providing the patient with the medicine, in order to ensure effective treatment of accompanying diseases. In this case, delivery of methadone to the patient should be done by medical personnel of the institution in which the patient is hospitalized.

Compulsory or mandatory drug dependence treatment

Kyrgyz law authorizes involuntary drug testing in numerous circumstances.

Upon enrolment in certain courses of higher educational institutions, applicants are required to undergo a general physical examination, which usually includes narcological testing. For example, persons applying for enrolment to military schools must pass a physical examination, including proof of absence of narcological disease.[888] In high schools, involuntary drug testing is done according to official Government guidelines for detecting drug use by minors.[889]

In addition, persons applying for a driver's license are required to undergo a physical examination, including drug testing.[890] Drivers of commercial vehicles are allowed to drive after passing an obligatory periodic physical examination based on the procedure established by the Ministry of Health.

Kyrgyz law also provides that compulsory treatment for drug dependence may be carried out by court order in two circumstances.

First, a court may order compulsory treatment for a person diagnosed with drug dependence who avoids voluntary treatment or who continues the non-medical use of drugs after undergoing treatment, in response to an application by relatives to law enforcement bodies or a prosecutor's office in connection with the person's dangerous behaviour.[891] Such persons are referred for treatment to specialized medical institutions of the public health services; minors older than 16 are sent to specialized medical educational institutions. People with disabilities (of either Category 1 or Category 2 severity, which means more serious disabling conditions), pregnant women and mothers with newborn babies, or persons with serious mental disorder or other serious illness that precludes compulsory treatment, are not subject to compulsory treatment. The duration of compulsory treatment cannot exceed twelve months.[892]

887 Ibid.

888 Ministry of Defence of KR"Instruction on physical examination of students and candidates seeking admission to military schools", [Инструкция Инструкции по медицинскому освидетельствованию воспитанников военного лицея и кандидатов, поступающих в лицей], No. 199 (9 September 2000).

889 Ministry of Health of KR "Instruction on the order for the preventive medical examination in educational institutions of the Kyrgyz Republic to detect minors consuming narcotic and psychotropic substances" [Инструкция о порядке проведения профилактического медицинского обследования в образовательных учреждениях Кыргызской Республики на предмет вызявления несовершеннолетних лиц, допускающих потребление наркотических и психотропных веществ], Instruction No. 468/662/1 (15 November 2002).

890 "Regulation for examinations, issuance to citizens of driver's licenses and the admission of drivers to driving vehicles", No. 420 (4 August 1999).

891 *Law "On narcotic drugs, psychotropic substances and precursors"*, Article 1.

892 This information was reported by the national expert group.

Second, a person convicted of a criminal offence may be ordered to undergo compulsory treatment for drug dependence, in addition to his or her sentence.[893] If a sentence does not include incarceration, drug dependence treatment takes place in health care institutions. If the sentence does include incarceration, compulsory drug dependence treatment is conducted in the penitentiary. If there is a need after release to continue compulsory treatment, it is provided in general health care facilities. Drug dependence treatment is not provided as an *alternative* to imprisonment, although this is permissible under international law. International drug control treaties explicitly allow States Parties to include, in their domestic legislation, *alternatives* to conviction and incarceration for drug offences, including providing treatment and rehabilitation services, instead of adding these on top of criminal sentences.[894] There appears, therefore, to be room for Kyrgyzstan to change its current legislative approach of imposing compulsory treatment *in addition to* other criminal punishment, and instead provide for treatment as an alternative. (Treatment must, of course, be in accordance with good, evidence-based clinical standards and with human rights.)

International organizations underline the principle that drug dependence treatment should generally be voluntary.[895] As a general proposition, compulsory medical treatment violates human rights, including to liberty, security of the person and privacy,[896] and should be applied only in extreme, clearly defined cases with a view to preventing a person from causing imminent, serious harm to himself or herself or to others. There appears to be a need to tighten current Kyrgyz law to circumscribe more narrowly the bases on which compulsory treatment may be imposed.

More broadly, as the national expert group has recommended, the Government of Kyrgyzstan needs to change the out-dated legislative guidelines, dating back to the Soviet period, that deal with procedures for drug testing, compulsory treatment and the registration of people who use or are dependent on drugs. The national expert group has concluded that there is a need to define a proper legal framework for the prevention, diagnosis and treatment of drug dependence. Therefore, the Government should draft and enact a law specifically dedicated to legal, medical and social measures for reducing drug dependence and the harms associated with drug use. Such legislation should explicitly address measures to ensure access to substitution therapy and should include: guarantees of patients' rights to voluntary treatment and to give informed consent to treatment; the protection of patients' confidentiality; and protection against discrimination.

Overdose prevention

According to Government Resolution, the medication naloxone, used to reverse opioid overdoses and prevent them from becoming fatal, is included in the national list of essential medicines in Kyrgyzstan,[897] making it one of the few countries in the region to do so. This is an important initiative. However, outreach workers of harm reduction programmes are not authorized to administer it or distribute it to people who use drugs and are most likely to be present when it needs to be administered quickly to someone who have overdosed. The national expert group has identified this as an issue requiring attention.

4B. HIV PREVENTION AND TREATMENT

According to Articles 5 and 6 of the *Law "On HIV/AIDS in the Kyrgyz Republic,"*[898] citizens, stateless persons and foreigners on the territory of Kyrgyzstan are also entitled to:

- voluntary, confidential HIV testing and medical supervision in facilities of the public health services;
- guaranteed minimum of information on HIV/AIDS and prevention measures;
- *participation in HIV prevention programmes and access to prophylactics (disinfectants, clean sy-*

893 *Criminal Code*, Article 90(2). A person may also be ordered to undergo treatment for tuberculosis, venereal diseases or HIV infection (discussed further below).

894 *Single Convention on Narcotic Drugs*, 1961, UN, 520 UNTS 331, as amended by the 1972 Protocol, Article 36(2); *Convention on Psychotropic Substances*, 1971, UN, 1019 UNTS 175, Article 22; *Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances,* 1988, Article 3(4).

895 UNODC and WHO, *Principles of Drug Dependence Treatment: Discussion Paper* (March 2008).

896 *International Covenant on Civil and Political Rights*, 999 U.N.T.S. 171 (1966), Articles 7, 9 and 17; *Universal Declaration of Human Rights*, UN General Assembly Resolution 217A (III), UN Doc. A/810 (1948), Articles 3 and 12.

897 Government Resolution "*On the List of essential medicines in the Kyrgyz Republic*" [Об утверждении Перечня жизненно важных лекарственных средств Кыргызской Республики], No. 759 (31 October 2006).

898 *Law "On HIV/AIDS"*, Law No. 149 (13 August 2005).

ringes, needles and condoms) [emphasis added];
- specialized, qualified medical aid in the field of HIV/AIDS; and
- to receive full information on their rights and on the nature of their health conditions and treatment methods; to qualified legal aid and psychological support; and to the realization of the sexual and reproductive rights.

According to the *Law "On HIV/AIDS"*, staff of the National AIDS Association, the Ministry of Education and Science, the department responsible for initial vocational training within the Ministry of Labour and Social Development, together with NGOs, carry out health education, including on HIV/AIDS, for general schools and vocational training institutions.

HIV prevention among people who use drugs

Needle exchange programmes have operated in Kyrgyzstan for about 10 years; they are generally run by non-governmental organizations. For over five years, needle exchange programmes have existed in the penitentiary system in Kyrgyzstan. Kyrgyz law also allows for the free acquisition of syringes from drugstores.

There is no defined legal framework specifically governing needle exchange programmes, although the NGOs that largely run such programmes have adopted their own internal policies. According to the national expert group, the Ministry of Health should be responsible for drafting, adopting and implementing uniform instructions for operating needle exchange programmes.

Needle exchange programmes include peer outreach workers among their personnel. According to the national expert group, in selecting outreach workers for participation in NSPs, administrators consider a person's remission period (usually three years abstinence from drug use is required) and their ability to interact with other people using drugs without returning to drug use. In practice, however, according to the expert group, there may be cases where outreach workers can be active users of drugs. The basic services provided by outreach workers include: distributing of sterile syringes/needles, condoms, sterile tampons and disinfectants; motivational interviewing to assist people in connecting to health services, including drug treatment; providing information and educational materials; peer education and training to potential peer educators; and preventing overdoses.

Outreach workers' activities are not regulated by Kyrgyz law, meaning the standards, rules and conditions of their activity are not defined and there are no guarantees of legal and social protection (which also means outreach workers may bear a risk of liability for their activities). More broadly, as noted above, the national expert group has observed that Kyrgyz law does not provide clear a legal framework for harm reduction programmes, which could put the beneficiaries of services, as well as medical, social and other staff involved in harm reduction services, at risk legally. The national expert group has suggested drafting and adopting a special law devoted to the legal, medical and social security of all actions related to harm reduction.

HIV testing

Voluntary testing

Kyrgyz law states the general rule that HIV testing is voluntary, done only with written consent of the person being tested.[899] Every HIV test should be accompanied by a pre- and post-test psychosocial counselling, performed by medical personnel such as doctors, nurses and social workers.[900] According to the Ministry of Health, during pre-test counselling, the test provider is required to give the patient enough time to consider the matters being discussed, check how well the patient understood the information and eliminate misunderstanding, ask the patient whether she or he agrees to take the test, and complete the informed consent form which must be signed by the patient to be valid.[901]

899 *Law "On HIV/AIDS"*, Article 8.

900 Government Order No. 296.

901 Ministry of Health, Order "On approval of new clinical reports", Order No. 218 (1 June 2005).

Compulsory testing upon request by law enforcement bodies

Under current Kyrgyz law,[902] compulsory HIV testing may be conducted by court order on the basis of an application by the police or public prosecutor; nobody but the police officer who initiated compulsory testing or the public prosecutor has the right to receive the results of the test.[903]

Mandatory testing

Kyrgyz law also provides for mandatory, confidential HIV testing in a number of circumstances.

First, donors of blood and other biological materials are, appropriately, subject to mandatory HIV testing as a condition of donating.[904]

Second, foreign citizens and stateless persons are required to get an HIV test after arrival in the country and during annual preventive medical examinations, if it is stipulated in international treaties binding on the Republic of Kyrgyzstan.[905] In practice, according to the national expert group, this means that foreign citizens are subject to HIV tests only in those cases where Kyrgyzstan has an agreement with the person's state of citizenship on requiring HIV certificates. Foreigners are subject to administrative deportation from Kyrgyzstan only in the case of deliberately evading obligatory testing. In such a case, the authorities must prove in court that the person maliciously evaded testing and refused or failed to follow the instructions of passport and visa control bodies on testing. The national expert group has noted that if a foreign citizen tests HIV-positive, but did not attempt to evade testing, administrative deportation is not applied. Administrative deportation is enforced by the law-enforcement bodies on the basis of a court decision.

Finally, pre-employment HIV testing is authorized in the case of employees in certain trades and occupations described in an approved government list.[906] This list includes medical workers who perform invasive procedures.[907]

A number of these articles and practices contradict the right to voluntary medical examination for HIV infection, as recognized in Kyrgyz law, and arguably rights that are supposed to be protected by the Constitution, such as freedom from discrimination (see Section 5 below). In addition, according to international standards, an HIV test should be done on a voluntary basis only, except for obligatory tests for donors of blood and organs.[908] If HIV testing is ever to be imposed without consent, then it requires a process clearly set out in law, with a requirement that such measures be taken only in exceptional circumstances and with adequate justification that must be considered by an independent, judicial body, and with the most limited infringement of human rights possible.[909] In addition, the national expert group has expressed concern that involuntary HIV testing risks driving "at risk" groups underground and creating additional barriers to effective HIV prevention and treatment.

HIV treatment

As noted above, the *Law "On HIV/AIDS"* stipulates access to medical services for persons living with HIV. All kinds of health care services and medicines for Kyrgyz citizens living with HIV are free of charge in the public health care facilities. Citizens living with HIV and AIDS are included in the list of people who have free health care based on their social status.[910] Such free treatment is not available to non-citizens.

902 *Law "On HIV/AIDS"*, Article 7.

903 Even when conducting HIV testing without the consent of the patient, medical workers are still under a duty to provide pre- and post-test counselling, although obviously the objective of ensuring informed *consent* to the test is irrelevant in such circumstances.

904 *Law "On HIV/AIDS"*, Article 8.

905 *Ibid.*

906 *Law "On HIV/AIDS"*, Article 8; Government of the Kyrgyz Republic, "Rules for medical examination to detect HIV, medical registration and observation of people with positive and ambiguous HIV tests in the Kyrgyz Republic", Government Resolution No. 296 (25 April 2006).

907 "List of workers of manufactures, works, trades and posts which are subject to obligatory physical examination", approved by Government Resolution No. 296, ibid.

908 *UNAIDS/WHO Policy Statement on HIV Testing* (June 2004).

909 Guidelines such as the UN's *Siracusa Principles* on permissible limitations on human rights should be complied with in any legislative provision that would allow involuntary testing or treatment: UN Economic and Social Council, *Siracusa Principles on the Limitation and Derogation Provisions in the International Covenant on Civil and Political Rights*, UN Doc. E/CN.4/1985/4, Annex (1985).

910 The program of state guarantees defines eligibility for free health services based on two categories of patients: List I ("Categories of population eligible for free medical services based on social status") includes persons living with HIV/AIDS, with services to be provide for free within the limits of funds available from the Global Fund to Fight AIDS, Tuberculosis and Malaria; and List II ("Categories of population having the right to free reception of medical services under clinical indications under the main disease"), which includes people with acute hepatitis.

According to the national expert group, AIDS centres exist only at the regional level; in rural areas, preventive and medical assistance in relation to HIV/AIDS is performed by family health care centres and family doctors under the supervision of the AIDS centres. There is collaboration between health care facilities which provide treatment for HIV, drug dependence, tuberculosis and hepatitis, including a referral system from one health care facility to another and joint consultations with participation of experts from each involved institution.

According to the national expert group, drug use cannot be a cause for refusing a patient treatment for HIV, hepatitis or tuberculosis**.** Legislation establishes procedures for providing ARV therapy to HIV-positive people who use drugs.[911]

Patients' rights, including confidentiality
Patients' rights are addressed in Chapter IX of the *Law "On health protection in the Kyrgyz Republic"*, which provides such rights of patients as:

- the right to high-quality medical and sanitary assistance;
- the right to fair and humane treatment;
- the right to testing, prevention, treatment and medical rehabilitation; and
- access to lawyer or other representative for protection of a patient's rights.

In case such a right is infringed, a patient may file a complaint with the head or another official of the facility, the appropriate professional medical organization or the court.[912]

By law, the fact of seeking health services, the state of health of a patient, a diagnosis and other information received from a patient through examination and treatment are "medical secrets" which must be kept confidential by health professionals.[913] Unauthorized disclosure of medical secret is a criminal offence.

However, disclosing medical secrets without a patient's consent is allowed in the following circumstances, which are very broad exceptions to confidentiality and give rise to some concern:

- if there is a risk of transmission of infectious diseases or mass poisonings and harm to others;
- upon request by investigative bodies, a public prosecutor or a court;
- in order to inform the parents or lawful representatives of a minor receiving medical assistance; and
- if there are grounds to believe that harm to the health of a person resulted from illegal actions.[914]

911 Ministry of Health, Order "On the approval of new clinical reports", Order No. 218 (1 June 2005), Section III.

912 *Law "On health protection in the Kyrgyz Republic"*, Article 72.

913 *Ibid*., Article 91.

914 *Ibid.*

5. PRISONS

According to the *Penal Code of Kyrgyzstan*, correctional facilities include colony-settlements, corrective colonies, educational colonies and prisons.[915] Corrective colonies are divided into colonies of general, strengthened, strict and special security modes. A distinctive feature of Kyrgyzstan's correctional system is the possibility of private correctional facilities in addition to state facilities.

In implementing the *Comprehensive Programme of Development of the Kyrgyz Republic for the period until 2010*, the Government is pursuing reforms of the judicial system and law enforcement bodies. Within the scope of this reform, presidential decrees[916] and governmental orders[917] transferred responsibility for the penitentiary system from the Ministry of Internal Affairs to the Ministry of Justice. In 2006, the Ministry of Justice established a Public Supervisory Board for the correctional system. The main functions of the Board are to: improve interaction between NGOs and correctional institutions; develop proposals to bring domestic legislation in line with international human rights standards, and further humanize conditions of serving punishment; and create conditions for the observance of rights and legitimate interests of the staff of the penitentiary institutions, prisoners and persons in pre-trial detention.[918] In June 2007, the President signed the Law directed at "humanizing" the country's criminal law by abolishing capital punishment and promoting alternatives to incarceration for sentencing, including for drug-related crimes.[919]

Incarceration of people who use drugs
According to the Penitentiary Department of the Ministry of Justice, in 2006, 1679 persons (12.4% of the total prison population) had been convicted of crimes related to drugs. Of these, 986 persons (58.7%) were sentenced to imprisonment, 398 persons (23.7%) to pay a fine, 8 persons (0.5%) to payment of threefold *ayip* (compensation of damage), 11 persons (0.7%) to public works and "arrest", and 276 persons (16.4%) to a conditional sentence.

As of 1 October 2007, there were roughly 13,000 people in prison in Kyrgyzstan. Of this total, 1901 persons (approximately 15%) were in prison for drug-related offences.[920] On 1 January 2007, 940 prisoners were ordered to undergo compulsory drug dependence treatment; of these, 191 were people with alcohol dependence and the other 739 were people with dependence on narcotics or psychotropic substances. According to the results of surveys conducted by non-governmental, international organizations and independent experts in Kyrgyzstan's correctional system, about 35% of prisoners actually use drugs while in prisons (about 50% of whom use drugs by injection).[921]

HIV, drug dependence and other health concerns in prisons
As noted above, in 2006, the penitentiary system registered 21 cases of viral hepatitis, 237 cases of syphilis, 21 cases of gonorrhoea and 41 new HIV infections. As of 1 January 2007, there were 102 prisoners in the country known to be HIV-positive (6 of them receiving ARV therapy).[922] In 2008, the Ministry of Health reported the total number of 178 of prisoners with HIV, including 12 prisoners with HIV/tuberculosis co-infection. Tuberculosis is another significant health concern in Kyrgyzstan's prisons. In 2006, the country's correctional institutions detected 532 cases of primary tuberculosis. As of 1 October 2007, correctional institutions had 2483 persons with active forms of tuberculosis on the dispensary account of which 1242 were active TB carriers.

915 *Penal Code of Kyrgyzstan* [Уголовно-исполнительный кодекс Кыргызской Республики] (11 November 1999, last amended by Law No. 91, 25 June 2007) [hereinafter "*Penal Code*"], Article 46.

916 President of the Kyrgyz Republic, Decree on "Measures for further improvement of the penitentiary system of the Kyrgyz Republic", Decree No. 305 (24 October 2001).

917 Government of the Kyrgyz Republic, Order "On procedure and conditions for protection of correctional facilities and convoying prisoners and persons in custody", Order No. 310 (17 May 2002); Government of the Kyrgyz Republic, Order "On transfer of the penitentiary system of the Ministry of Internal Affairs of the Kyrgyz Republic to the purview of the Ministry of Justice of the Kyrgyz Republic", Order No. 319 (20 June 2002).

918 Ministry of Justice, Order No. 166 (16 November 2006).

919 *Law "On amendments to the Criminal Code of the Kyrgyz Republic, the Code of Criminal Procedure of the Kyrgyz Republic, the Penal Code of the Kyrgyz Republic, Code of the Kyrgyz Republic on Administrative Responsibility, Laws of the Kyrgyz Republic 'On the Supreme Court and local courts', 'On the Office of Public Prosecutor of the Kyrgyz Republic', 'On the Order and conditions for holding in custody of persons detained upon suspicion and charged with crimes', 'On general principles of amnesty and pardon', 'On coming into force of the Code of Criminal Procedure of the Kyrgyz Republic' and the Law 'On introduction into force of the Criminal Code of the Kyrgyz Republic'"*, Law No. 91 (25 June 2007).

920 Data provided by the national experts [on file].

921 Data provided by the national experts [on file].

922 Data provided by the national expert group [on file].

Organization of health care in prisons

The *Penal Code* requires the organization of medical correctional facilities to contain and ensure outpatient treatment of prisoners with HIV, active tuberculosis, or chronic alcohol or drug dependence.[923] Kyrgyz law also provides for the oversight of the correctional system by the public and by NGOs.[924]

In order to coordinate activity in the field of prison health care services, in 2006 the Ministry of Justice established an Information & Analytical Centre on health protection in the correctional system, tasked with collecting statistical information, creating a database and monitoring all programmes and projects in the field of prevention and treatment of socially significant diseases within the correctional system. Preventing HIV and related infections is a major area of attention. NGOs are involved in responding to HIV in prisons; the work with NGOs on HIV prevention in prisons is carried out by the Ministry of Justice and the chief department of the penitentiary on the basis of bilateral agreements, memoranda, within various projects.[925]

In 2006, the Government established a working group for social rehabilitation of prisoners.[926] In addition, in 2007 three ministries jointly created an inter-departmental Council to coordinate the planning, preparation, introduction and monitoring of the *Programme on health protection and social support of prisoners*.[927] The Council is a collective advisory body of representatives of state bodies, international and non-governmental organizations; it defines the strategy for reforming public health services in prisons, co-ordinates the work of health care facilities within the correctional system and promotes creation of a system of social support within the system.

[Interviews with prisoners about provision of medical services]

In order to assess the quality of health care services in the correctional system, the national expert group interviewed several prisoners on anonymous basis in August 2007 in Colony-Settlement No. 36 in Bishkek. The sample size was small, but identified some areas of concern that warrant further investigation and attention.

Out of four interviewed respondents, *Respondent A* relayed that he sought health care treatment for an infectious disease and was hospitalized in the hospital of the penitentiary. He stated that health care staff provided only consultations and diagnostics; medication had to be bought by his relatives and sent from outside the prison.

Respondent B sought medical assistance during incarceration many times and was hospitalized in the Central Hospital of the correctional system for about one month after a drug overdose. Respondent B underwent treatment for drug dependence in the rehabilitation centre "Atlantis" and was not using drugs at the time of the interview. According to the respondent, after many complaints of headaches in the pre-trial facility (SIZO), health care staff gave him only aspirin, analginum and sometimes ascorbic acid. Required medicines for the cold and headache were purchased and delivered by his mother, or if he had money, he purchased them himself.

All respondents said the only difference between health care services in a corrective colony and a pre-trial detention facility is that access to health care workers is easier in a colony than in pre-trial detention centres. In both colonies and pre-trial detention facilities, medicines are often not available or have just run out, meaning all hope rests with relatives. All respondents noted the absence of such experts as dentists, STI specialists, dermatologists and other specialists.

Drug testing and drug dependence treatment

At this writing, no special medical correctional facilities exist for prisoners with drug dependence. Under the Ministry of Justice, the Narcological Centre, a division of the Central Hospital of the penitentiary, offers

923 *Penal Code*, Article 73.

924 *Law "On bodies and establishments of the penitentiary system"*, Law No. 197 (12 August 2003).

925 *Penal Code*, Article 23(2); Ministry of Justice, Order "On approval of the Statute 'On the order of interaction between establishments of the Ministry of Justice of the Kyrgyz Republic with the public, international, religious and other organizations,'" Order No. 150 (23 December 2005).

926 Ministry of Justice, Ministry of Health, and State Committee on Migration and Employment, Joint Order No. 131/183-shs/204a (15 September 2006).

927 Order "On Interdepartmental Coordination Council on Health Protection and Social Support in the Penitentiary System" [Межведомственный координационный совет по охране здоровья и социальному сопровождению в уголовно-исполнительной системе], Joint Order of Ministry of Justice No. 49 (25 April 2007), Ministry of Health No. 179 (23 April 2007) and Ministry of Labour and Social Development No. 32 (25 April 2007).

150 beds. The overall objective of the Centre is coordination of treatment and prophylactic assistance to persons with drug dependence, and greater efficiency and better quality of diagnostics, treatment and rehabilitation services for patients.

Voluntary treatment of drug dependence is carried out in the "Atlantis" Rehabilitation Centres, which provide psychological support, restoration of broken social relationships and 12-step programmes for people with alcohol and drug dependence. With support from the Soros Foundation of Kyrgyzstan and the Central Asian HIV/AIDS Programme (CARHAP), "Atlantis" Rehabilitation Centres have been established in seven correctional facilities of the country. The Ministry of Justice has undertaken measures to provide structural change to ensure new methods of work with people with drug dependence, and institutionalization of the Atlantis Rehabilitation Centres.[928]

Prisoners are compulsorily tested for drug use only if there is court decision on compulsory treatment in addition to the criminal sentence. Testing is carried out upon prisoners' arrival in the narcological centre of the correctional facility.[929] Compulsory treatment of drug dependence consists of detox therapy, general health-care measures and individual psychotherapy. Narcologists determine treatment methods, taking into account the specific attributes of patients and the presence of accompanying diseases.[930] According to the national expert group, persons released from prison receive advice on the possibility of continuation of treatment in the civil sector of public health services and their location. Thus, after release people can voluntarily seek treatment.[931]

According to the national expert group, reforms to the narcological service of the correctional system are being implemented as part of a project on addressing drug use in prisons, which also established a basis for introducing OST in prisons.[932] This has included opening a branch for detox and substitution therapy programme in the Narcological Centre of the Central Hospital of the correctional system (in colony #47) and one "Atlantis" Rehabilitation Centre in Jalalabat. In 2006, with support of the AIDS Foundation East-West, a project on social support of persons who are released from the correctional facility was launched at the same institution. The decision has also been made to develop a network of social support services by opening Social Bureaus in nine more correctional facilities and one pre-trail detention facility (with funding from CARHAP). As of August 2008, there was a pilot project of OST in the correctional system and in two pre-trial detention centres.

HIV prevention programmes in prisons, including harm reduction measures

HIV prevention measures in the Kyrgyz correctional system include:

- provision of information and educational programmes;
- access to HIV testing and counselling;
- needle exchange programmes for people who inject drugs; and
- distribution of condoms in conjugal meeting rooms and in needle exchange programmes.

At this writing, according to the information presented by the national experts, facilities for HIV counselling and testing have been established in five correctional institutions with support from the Global Fund to Fight AIDS, Tuberculosis and Malaria.

Kyrgyzstan has been a leader in the region, and amongst the leaders globally, in implementing needle exchange programmes in prisons. The Ministry of Justice has issued several regulatory acts, allowing distribution in the penitentiary system of the country of information on HIV, needles and syringes, organization on a voluntary basis of self-help groups and peer education services.[933] Government regulations

928 Ministry of Justice, Order "On organizational measures and staffing," Order No. 216 (29 December 2006).

929 *Law "On narcotic drugs, psychotropic substances and precursors,"* Article 37.

930 "Instructions on the terms and conditions for the narcological assistance to persons with mental and behavioural disorders caused by use of psychoactive substances in the penitentiary" (co-coordinated with the Ministry of Health) (24 April 2007), approved by the Ministry of Justice, Order No. 48 (25 April 2007), paras. 2 and 4.

931 *Ibid.*, paras 16 and 19.

932 Project: "Prevention of the use of drugs in prisons", part of the Program on "Prevention of drug dependence in Central Asia" (CADAP) with support of the European Union and UNDP.

933 Order "On conditions and order for the pilot project on exchange of syringes and needles among injection addicts in correctional facilities of the GUIN MJ of the Kyrgyz Republic," Order No. 148 (7 October 2002); Order "On realization of exchange of syringes and needles projects among injection drug users in correctional facilities of GUIN of the Ministry of Justice," Order No. 50 (17 March 2004).

also address such matters as measures of HIV prevention, dissemination of information, establishment of harm reduction programmes. According to the recent amendments to these rules, syringes are no longer forbidden in the correction system of Kyrgyzstan.[934] Needle exchange programmes have been implemented in 10 correctional facilities; as of 2008, there were 14 points where prisoners could gain access to sterile injection equipment. These programmes include not only the provision of sterile equipment, but also the distribution of disinfectants, training on how to reduce risks associated with injection (including HIV risks), individual counselling, information and psychological support to people who use drugs, and consultations with health care staff and referral to testing for HIV, STIs and hepatitis.

Treatment for prisoners with HIV

As of January 1, 2007, there were 102 prisoners with HIV, 6 of whom were receiving ARV treatment, 2 other refused or stopped therapy.[935] According to UNODC, data from the Ministry of Health for 2008 indicated there were 178 people living with HIV in Kyrgyz prisons, 12 of whom had HIV/TB co-infection.[936]

According to the Penal Code of the Kyrgyz Republic, not only people with drug dependence are subject to compulsory treatment. People with HIV, active forms of TB, and patients who have not completed the full course of STI treatment, based on the decision of a medical committee of the penitentiary institution, may be ordered by the penitentiary to undergo compulsory treatment.[937]

Discrimination based on HIV status or drug dependence in prisons

According to the national expert group, in most respects conditions for HIV positive prisoners are not different from conditions for other prisoners. However, a special feature of the Kyrgyz correctional system is that people living with HIV are housed separately (segregated) from the rest of the prison population.[938] This is contrary to international policy: the *International Guidelines on HIV/AIDS and Human Rights* advise that states should prohibit segregation of HIV-positive prisoners.[939]

Other discriminatory provisions of the penal legislation of Kyrgyzstan include the following:

- Certain categories of prisoners are prohibited from being transferred without an escort or from being temporarily outside prison with authorization. This includes prisoners sentenced to compulsory treatment of alcohol and drug dependence, tuberculosis, venereal disease and HIV-infection.[940]
- In addition, these same categories of prisoners are not allowed to take short-term leave from prison in emergency personal circumstances.[941]

Such restrictions are also contrary to international policy guidance: again, the *International Guidelines* recommend that States should not deny access to privileges and release programmes to prisoners based on HIV status.[942]

934 Government of the Kyrgyz Republic, Order "On regulations for pre-trial detention facilities (SIZO)", Order No. 229 (16 May 2008).

935 Information presented by the expert group [on file].

936 UNODC, "Kyrgyzstan: General Information", 2008 [on file].

937 *Penal Code*, Article 17(3).

938 Ministry of Justice, Order No. 164 (28 October 2003) № 164, in coordination with the State Office of Public Prosecutor, "Regulations for correctional facilities of the Ministry of Justice of the Kyrgyz Republic".

939 Office of the UN High Commissioner for Human Rights & Joint United Nations Programme on HIV/AIDS, *International Guidelines on HIV/AIDS and Human Rights*, 2006 Consolidated Version, Guideline 4: Criminal Laws and Correctional Systems, para.21(e).

940 *Penal Code*, Article 68(2).

941 *Penal Code*, Article 69(3).

942 *International Guidelines on HIV/AIDS and Human Rights*, para. 21(e).

6. DISCRIMINATION AND RESTRICTION OF RIGHTS

Article 13 of the *Constitution of Kyrgyzstan* stipulates that "all people are equal in the Kyrgyz Republic before the law and the courts and that no person may be exposed to any discrimination or infringement of freedom and other rights based on descent, sex, race […] or *any other circumstances of personal or public character"*. The *Criminal Code* states that it is a criminal offence to violate equality.[943]

The *Law "On HIV/AIDS"* also address equality rights of PLHIV. Specifically, it prohibits:

- stigmatizing and discriminating against people living with HIV and people affected by HIV, as well as the infringement of their legitimate interests, rights and freedoms on the ground of HIV-infection;
- refusing to hire someone or terminating a person's employment, except for certain kinds of professional positions established by a special list;
- refusing to enrol someone in an educational institution or accept a person as a patient in a health care facility.[944]

These are welcome provisions. However, there remain aspects of Kyrgyz law that are of concern, in that they unjustifiably discriminate on the basis of HIV status or drug dependence.

Discrimination based on HIV status or drug dependence

One issue that remains of concern is the denial of family rights to persons living with HIV. Currently, persons with "serious chronic infectious diseases" cannot adopt children under Kyrgyz law.[945] Yet HIV status is not in itself a sufficient justification to deny equal treatment in adoption; rather, as with all such cases, the individual circumstances and ability of the potential parent must be assessed, with the consideration of the best interests of the child in mind. Misinformation and prejudice about HIV and PLHIV cannot be allowed to disentitle a person from adopting on this basis.

The review by the national expert group also identified discrimination against people who use drugs as an area of concern, given the objective of strengthening HIV prevention and care among this vulnerable population. The expert group's analysis suggested that Kyrgyzstan's legislation has provisions that need to be revised, primarily due to the fact that they themselves stigmatize and discriminate against people who use drugs. Examples include the following:

- *Discrimination in employment*: People who use drugs are prohibited from certain kinds of employment, in which mandatory drug testing is also imposed as part of the recruitment process (e.g., law-enforcement and drug control bodies, Office of the Public Prosecutor). If a medical commission finds that the person is not eligible based on health status (including drug use), recruitment is terminated.
-
- *Discrimination in family relations*: People with dependence on drugs or alcohol are prohibited from adopting children; there is no time limit on this prohibition specified in the law.[946] Adoption of a child can be considered void if adoptive parents do not perform parental duties; abuse their parental rights; engage in cruel treatment of adopted children; *or are chronically dependent on alcohol or drugs*.[947] Furthermore, in cases of concern about child abuse or neglect, *chronic drug dependence* may be an aggravating factor that is *per se* a basis for depriving parents of custody of a child, along with such other grounds as abuse of parental rights, cruel treatment and committing

943 *Criminal Code*, Article 134: "Direct or indirect infringement or restriction of the rights and freedom of the person and the citizen … is punished by a fine or corrective works for a term up to two years. The same act made with use of office status, is punished by a higher fine or imprisonment for a term up to two years."

944 *Law "On HIV/AIDS"*, Article 13 (Interdiction for restriction of the rights and stigmatization of persons living with HIV/AIDS).

945 Government Resolution [положение] "On rules of transfer of children who have remained without care of parents, on adoption to citizens of the Kyrgyz Republic, and foreign citizens" [Положение о правилах передачи детей, оставшихся без попечения родителей, на усыновление (удочерение) гражданам Кыргызской Республики, а также иностранным гражданам], Resolution No. 121 (22 February 2006).

946 *Ibid.*

947 *Family Code of the Kyrgyz Republic*, Law No. 201 (30 August 2003), Article 147.

a deliberate crime against the life or health of children. Automatic assumptions that the health condition of alcoholism or drug dependence should warrant removal of a child is is unjustifiable. Any deprivation of parental rights should be based on individualize assessments in the circumstances.

Currently, Kyrgyz law does not contain any provisions protecting people who use or are dependent on drugs from discrimination; it has only general provisions on protection against discrimination, which are insufficient in the light of identified patterns of discrimination, including against vulnerable groups such as people who use drugs, whose stigmatization and marginalization only impedes effective responses to HIV. According to the national expert group, the rights of people who use drugs are regularly infringed, including such things as: enforcement of compulsory medical testing and treatment; drug user registration and associated breaches of confidentiality; excessive measures of administrative and criminal punishment; the deprivation of parental rights; refusal to grant medical and social services and legal aid, etc.

In the estimation of the national expert group, a main reason for discrimination against people who use drugs is their continued criminalization. Current *Criminal Code* provisions, which cast all people who use drugs as criminals or potential criminals, contribute to the stigmatization of people who use drugs. Revisiting the approach that relies predominantly on criminalizing and punishing people for drug use is therefore necessary.

In addition, the national expert group has recommended enacting a law on narcological assistance and providing mechanisms for protecting patients against stigmatization and discrimination, including supporting and protecting those suffering from infringements of rights through illegal actions by government bodies.

7. RECOMMENDATIONS FOR LEGISLATIVE AND POLICY REFORM

In order to strengthen the response to HIV among people who use drugs and in prisons, the national expert group has recommended two things in particular: eliminating discriminatory provisions in Kyrgyz and providing appropriate financing of programmes that are adopted.

According to the national expert group, those populations vulnerable to HIV are also among the most marginalized populations in Kyrgyzstan. Much of the public, and many politicians and government representatives, view these groups as engaged in immoral activities and unworthy of protection and support. According to the national expert group, these attitudes are partly rooted in the ideological and legal trends towards rigid and repressive criminal and administrative policy and state compulsion of the Soviet period. Those who suffer most from such an emphasis on punitive methods for dealing with what are primarily health issues are those who are further marginalized by such inefficient and ineffective government policies and made more vulnerable to poor health and to human rights abuses as a result. The ostensible struggle against drugs has too easily become a programme of targeting people who use drugs for repression and punishment.

As the national expert group has noted, it is time to assess the reforms in 2007 to Kyrgyzstan's criminal law in the area of drugs. To their credit, in partly liberalizing the country's drug policy, the government and legislators have sought to mitigate punitive measures for people who use drugs or are drug-dependent. However, these reforms have been insufficient and not carried out consistently; further work, including further legislative reforms to further humanize Kyrgyz drug policy, is needed to avoid ongoing violations of human rights and to be more effective in addressing the health-related harms of drugs, including HIV. In the view of the national expert group, the *Criminal Code* amendments should have led to changes in enforcement of the law as well, but these have not been fully realized, as a result of deeply-rooted repressive tendencies, corruption, the absence of effective civilian oversight and, most importantly, the ongoing approach, inherited from the Soviet period, in which data about prosecutions and convictions is seen as the main indicator of "progress" in tackling the drug problem. This leads to situations where law enforcement staff can fabricate evidence by planting drugs and psychotropic substances, force self-incrimination or involve drug users in selling drugs. Such police practices undermine efforts to humanize the system through legislative reform.

According to the national expert group's assessment, the main goal of further reforms should be to move further away from criminal and administrative penalties as the primary approach to drugs and people who use them, and instead focus on the development of evidence-based programmes to prevent drug dependence, to treat people with drug dependence and to prevent or reduce harms associated with drug use, including HIV. In order to achieve more effective and longer-term solutions to problem drug use and related harms, the national expert group proposes to develop a new national drug policy with an emphasis on prevention, treatment and harm reduction, and an avoidance of repressive measures against people who use or are dependent on drugs. Further humanization of criminal and administrative provisions related to drug offences is required, with a view to achieving full depenalization of manufacturing, acquisition, possession, transportation or mailing of narcotic drugs and psychotropic substances *without an intention to sell*. It is also recommended that Kyrgyzstan reform its legislation to provide greater opportunities for alternatives to imprisonment, and that the government should also introduce non-compulsory treatment for drug dependence as well as enhanced services providing informed education aimed at preventing problem drug use and medical and social rehabilitation and reintegration of people who use drugs.

Among other shortcomings of the current situation with human rights of people who use drugs and prisoners in Kyrgyzstan, particularly noteworthy is the need for greater respect and protection for confidentiality, as well as ensuring access to information and that medical testing (including drug testing or HIV testing) is fully voluntary. Discrimination against people living with HIV/AIDS and members of vulnerable groups (such as people who use drugs) undermines access to health services and the effective implementation of preventive measures. The national expert group has noted the importance of legislatively binding guarantees regarding rights of the patient to treatment, informed consent and confidentiality of HIV tests, access to substitution therapy and protection from stigmatization and discrimination.

More detailed recommendations for reforms in these and other areas are listed below. The recommendations presented here are aimed at addressing issues identified by the national expert group of Kyrgyzstan and by the project's technical advisors. Suggested language of legislative amendments is shown in shaded boxes.[948]

National Programmes and Strategies

Recommendation 1: Ensure the effectiveness of the national response to HIV and narcotic drugs

In order to increase the effectiveness of current national programmes on HIV/AIDS prevention and narcotic drugs, the national expert group has recommended the following:

- increased financing of programmes;
- a clear definition of responsibilities of authorized bodies;
- develop national programmes for the prevention of STIs and hepatitis.

Recommendation 2: Develop a national drug policy with emphasis on public health

The national expert group has recommended developing a new national drug policy that emphasizes preventing drug misuse and preventing or reducing harms associated with unsafe drug use, while removing the emphasis on punitive and repressive measures against persons who use drugs (including those who are drug-dependent).

Administrative and criminal law issues

Recommendation 3: Remove intoxication as aggravating factor for criminal liability

According to the *Administrative Code* (Article 43) and *Criminal Code* (Article 55(16)), being intoxicated by drugs or alcohol while committing a crime is an aggravating circumstance. However, whether or not a person is intoxicated does not affect the gravity of the harm of his or her crime, so it should not be considered as making the crime more serious. Rather, such a provision effectively discriminates against people accused of offences based on their health status (i.e., dependence of drugs or alcohol), imposing harsher penalties for a given offence on people with this health condition. Article 43 of the *Administrative Code* and Article 55(16) of the *Criminal* Code should be repealed.

Recommendation 4: Remove criminal and administrative liability for possession of small quantities of drugs for personal consumption

The national expert group has suggested the Government should continue the initiative of "humanizing" the country's criminal and administrative laws dealing with drugs, with a view to achieving the full depenalization (i.e., neither criminal nor administrative penalty) of manufacturing, acquisition, possession, transportation or transfer of small amounts if narcotic or psychotropic substances without *intention to sell*. To this end, a number of steps should be taken.

(1) Currently, the *Administrative Code* (Article 366) appears to penalize even the mere *use* of narcotics or psychotropic substances. This should be repealed.

(2) One of the recommendations of the expert group is to define legislatively the concept of "personal consumption" and to provide alternatives to punishment for cases of acquiring and possessing controlled substances in a quantity intended for personal consumption, such as education and, where clinically indicated, treatment and medical and social rehabilitation. In implementing reforms to remove criminal and administrative liability for possession of quantities for personal use, the Government should enact a provision such as the following in a statute such as the *Law "On narcotic drugs, psychotropic substances and precursors*", the *Administrative Code* or the *Criminal Code* (or all three):[949]

> **Decriminalization [depenalization] of possession without intention to sell**
>
> Notwithstanding anything in this or any other statute, the possession and use of a [small quantity] of a narcotic or psychotropic substance listed in [relevant schedule/list] for personal use does not constitute a criminal or administrative offence.

(3) Removing penalties for activities involving quantities of drugs for personal use, including possession, also requires attention to the approach to how quantities of drugs are defined for purposes of administrative or criminal liability. In this regard, Kyrgyz law could be improved, so as to reflect real-world circumstances of drug use. To that end, *Governmental Order of the Kyrgyz Republic No. 543 (9 November 2007)* should be amended as follows:

- A quantity for "personal consumption" should be defined by reference to the known frequency of use on a daily basis and the quantity consumed per instance of use, although it would be a mistake to limit it too strictly to just a certain specified number of daily doses, as a person may possess a quantity for his or her use over several days.

- The national expert group also recommended defining the *lower* limit of the "small quantity" of narcotics, which at the moment is zero. The Government Order defining different quantities of drugs for administrative and criminal law purposes establishes only the *upper* limit of the "small quantity" [небольшие размеры] of various narcotic drugs and psychotropic substances, and does not define the lower limit of this category to reflect minimal amounts. In other words, the legal category of "small" quantity" includes *any* quantity, however minimal. In addition to penalizing people who use drugs and therefore possess even minimal quantities, this measure also creates potential liability for even residual amounts of narcotics, such as that found in a used syringe — this creates an incentive for people who use drugs to dispose of used syringes quickly and unsafely, rather than returning them to needle exchange programmes, and also means that outreach workers and other staff of needle exchange programmes are exposed to liability for possession.

- Finally, in defining various quantity ranges of different drugs, the law should make clear that this is a reference to a quantity of the pure drug itself, not the quantity that includes other fillers or additives that may be mixed with it.

Recommendation 5: Provide alternatives to imprisonment for some drug offences and establishing an extra-judicial Commission

The national expert group has recognized that one important measure of HIV prevention will be to reduce the frequency with which people who use drugs go to prison. Implementing Recommendation 4 above is one important way to achieve this, by removing criminal liability at least in the case of possession of small quantities of drugs for personal use.

In addition to taking such a step, to the extent that certain acts related to drugs remain criminal offences, at least the approach to punishing such crimes can be changed to reduce the use of imprisonment, with all the human and financial costs and harm to public health that imprisonment carries. The national expert group has recommended amendments to the *Criminal Code* to implement alternatives to imprisonment for non-violent offences related to drugs (without an intention to sell).

948 In many instances, the wording of proposed legislative amendments is adapted from model provisions in Legislating for Health and Human Rights: Model Law on Drug Use and HIV/AIDS (Toronto: Canadian HIV/AIDS Legal Network, 2006), online in both English (www.aidslaw.ca/modellaw) and Russian (www.aidslaw.ca/modellaw-ru). This publication, consisting of a series of 8 modules on different issues, was used as a key reference by UNODC, national expert groups and the project's technical advisors during the review and assessment of national legislation in the countries participating in the project. Where relevant, citations below are to specific modules of that resource; the accompanying text and commentary to be found in those modules may be useful to legislators and policy-makers in implementing these recommendations.

949 See *Legislating for Health and Human Rights: Model Law on Drug Use and HIV/AIDS*, Module 1: Criminal law issues, pp. 18-21.

The national expert group has recommended legislation to **establish a Commission** to deal with cases connected with illegal manufacturing, acquisition, possession, transportation or transfer of narcotics or psychotropic substances *in a small quantity without intention to sell*. A legislative provision such as the following, inserted into a statute such as the *Law "On narcotic drugs, psychotropic substances and precursors"* or the *Criminal Code*, could create the legal basis and mandate of the Commission:

Alternatives to prosecution and imprisonment for certain drugs offences

Option 1: Referral to quasi-judicial commission

(1) The sections below apply to the following offences involving a narcotic or psychotropic substance when those offense are committed in circumstances that do not involve violence and there is no accusation of an intent on the part of the accused person to sell said substance: i.e. under Articles 91-2 and 366 of the *Code of the Republic of Kyrgyzstan on Administrative Responsibility*, and Article 43 of the *Criminal Code:*

(a) Illegal possession, transportation or transfer of narcotics or psychotropic substances *without an intention to sell* and in a "small quantity" [небольшие размеры]
(b) The "use of narcotics or psychotropic substances, the consumption of alcohol in the streets, stadiums, parks, in public transport and in other public places, or appearing in public in a state of intoxication that offends human dignity and social morality"
(c) Being intoxicated by alcohol or a narcotic or psychotropic substance while committing an administrative offence

(2) The offences referred to in section (1) shall be processed, and penalties applied if applicable and necessary, by a quasi-judicial commission ("the Commission").

(3) The Commission shall include a legal expert, as well as other experts such as medical practitioners, psychologists, social service workers or others with appropriate expertise in the field of drug dependence.

(4) The rules of procedure governing the proceedings of the Commission, including the admissibility of medical evidence, shall be determined by the Ministry of Justice and the Ministry of Health.

(5) In arriving at the appropriate penalty for a person apprehended by police for the offences referred to in Section (1), the Commission shall consider:
(a) the seriousness of the act;
(b) the relative degree of fault;
(c) the type of substance involved in the offence;
(d) the public or private nature of the offence and, if relevant, the location of the offence;
(e) the personal circumstances, namely economic and financial, of the offender; and
(f) whether the offender is an occasional, habitual or dependent drug user.

(6) The Commission may apply penalties including, but not limited to, one or more of the following:
(a) a notice of caution;
(b) a fine in proportion to the amount of the narcotic or psychotropic substance possessed for personal use, taking into account the economic situation of the alleged offender;
(c) restriction on travel or attendance in certain places;[950] and
(d) suspension of driving or professional licences.

(7) The penalties applied by the Commission shall not include custodial penalties.

(8) If the person apprehended for the offences referred to in Section (1) is found by the Commission to be dependent on a narcotic or psychotropic substance, the Commission may order that the person attend a specified number of meetings with the provider of a drug dependence treatment programme, the purposes of which shall be to ensure the person is aware of the programme's services that may assist in overcoming drug dependence and to determine whether the person wishes to avail himself or herself of the services of the programme. The Commission may not compel the person to undergo drug dependence treatment.

950 Note that it will be important to avoid an order that prohibits the person from entering an area where important health services (e.g., needle and syringe programs, health clinics, etc.) are located.

Another option for creating alternatives to imprisonment could be achieved by enacting the following provision:

Option 2: Non-custodial sentencing measures

(1) Notwithstanding the provisions of this or any other statute, where
(a) a person is found guilty in a court of law of the offence of possession of a narcotic or psychotropic substance contrary to the law;
(b) in the court's opinion, taking into account the quantity of the substance possessed and all other relevant circumstances of the case, the use or possession of a narcotic or psychotropic substance was for the purpose of personal use; and
(c) the applicable sentence would ordinarily include a custodial sentence;

a court shall, rather than imposing a custodial sentence, order one or more of the following:

(a) direct that the person be discharged absolutely or on the conditions prescribed in a probation order;
(b) suspend the passing of sentence and direct that the person be released on the conditions prescribed in a probation order;
(c) fine the person, if the court is satisfied that the person is able to pay the fine;
(d) order that the person serve the sentence through community service, subject to the person's complying with the conditions of a conditional sentence order; or
(e) make a supervised attendance order with the consent of the person requiring him or her to attend a place of supervision for such time as is specified in the order and, during that time, to carry out such instructions as may be given to him by the supervising officer within the lawful exercise of that officer's authority.

(2) As a term of a probation order or a conditional sentence order in Section (1), the court may order that the person attend a specified number of meetings with the provider of a drug dependence treatment programme, the purposes of which shall be to ensure the person is aware of the programme's services that may assist in overcoming drug dependence and to determine whether the person wishes to avail himself or herself of the services of the programme. The court may not compel the person to undergo drug dependence treatment.

(3) The court may make an order as described in Section (1) if the court considers it to be in the best interests of the accused and not contrary to the public interest, having regard to the age and character of the offender, the nature of the offence and the circumstances surrounding its commission. In making such a determination, the court shall consider the results of any clinical assessment that may have been made of the person.

Recommendation 6: Preclude criminal or administrative liability for harm reduction programmes

In order to ensure they are most effective in advancing their mandate of protecting and promoting health, the harm reduction and outreach activities of non-governmental organizations targeting people who use drugs, such as programmes providing sterile syringes or other equipment to reduce harms associated with drug use (including HIV transmission), should be clearly exempt from possible legal liability. To this end, the national expert group has recommended a legislative amendment to add the following text to Article 249 of the *Criminal Code* (specifically in relation to the offence of "inducing consumption"):

The present article does not apply to cases of distributing information aimed at preventing infection with HIV or other infectious diseases among people who use narcotic or psychotropic substances or the distribution of corresponding tools and equipment for this purpose.

It is suggested that this recommendation should also extend to other aspects of the law creating a similar risk of legal liability, which aspects should be addressed in a similar fashion. In particular, harm reduction programmes also should be clearly exempt from liability for "organization or maintenance of sites" for the consumption of drugs (*Criminal Code*, Article 252). Wording such as the proposal above could easily be added to these other existing provisions as well, to achieve the same effect.

Recommendation 7: Limiting compulsory drug testing in the law

According to the information presented by the national experts and described above, currently, compulsory testing is conducted mainly following referral by police, in cases where police suspect illegal activities. While this is a very broad application of compulsory testing, Article 36 of the *Law "On narcotic drugs, psychotropic substances and precursors*" also includes other, broadly-worded provisions. Yet compulsory drug testing violates privacy and security of the person, without justification in most circumstances, since merely showing past use of drugs does not prove there is a serious risk of harm to self or others, which should be the only basis for possibly justifying an intrusion by the state into such rights. Furthermore, the national expert group has raised the concern that this very broad power of police to compel people to undergo drug testing simply based on police suspicions of a crime opens the door to police abuses, including extortion. To eliminate unjustifiably broad provisions for compulsory drug testing, it is recommended that, at the least, Article 36 of this law to specify that "compulsory drug testing is possible only following a court order."

Recommendation 8: Eliminate HIV and STI-specific criminal law

Articles 117 and 118 of the *Criminal Code*, which specifically provide liability for transmission and exposure to "venereal diseases" and HIV, should be repealed, in line with international policy recommendations.[951] In the case of intentional transmission of venereal or HIV infection, this could be dealt with as infliction of bodily harm that is covered by other articles of the *Criminal Code*.

Health care

Recommendation 9: Revisit operation of drug user registry

The current system of registration of drug users is one factor that discourages people from seeking medical treatment, including for drug dependence, and may provide a basis for various infringements of confidentiality. It is therefore recommended that the government begin an assessment of the efficacy and cost-effectiveness of the current approach. Article 36(3) of the *Law "On narcotic drugs, psychotropic substances and precursors"* should be repealed.

Recommendation 10: Limit the use of compulsory treatment of drug dependence

Articles 40 of the *Law "On narcotic drugs, psychotropic substances and precursors"* on drugs specifies who may be referred to compulsory treatment flowing a court decision: a) people recognized as having drug dependence, but who evade treatment, or people who have continued to use drugs after treatment; and b) people in relation to whom police have received an application from relatives based on the person's "dangerous behaviour." International organizations underline the principle that drug dependence treatment should generally be voluntary.[952] As a general proposition, compulsory medical treatment violates human rights, including to liberty, security of the person and privacy,[953] and should be applied only in extreme, clearly defined cases with a view to preventing a person from causing imminent, serious harm to himself/herself or to others. It is recommended that Article 40 be clarified and narrowed by rewording it to authorize compulsory treatment of drug dependence only in cases where there is a significant risk of serious harm to oneself or others.

951 *International Guidelines on HIV/AIDS and Human Rights,* Guideline 4, para. 21(a); UNAIDS, *Policy Brief: Criminalization of HIV Transmission* (2008).

952 UNODC and WHO, *Principles of Drug Dependence Treatment: Discussion Paper* (March 2008), p.9.

953 *International Covenant on Civil and Political Rights*, 999 U.N.T.S. 171 (1966), Articles 7, 9 and 17; *Universal Declaration of Human Rights*, UN General Assembly Resolution 217A (III), UN Doc. A/810 (1948), Articles 3 and 12.

Recommendation 11: Protect confidentiality, improve access to voluntary drug dependence treatment

The national expert group has recognized that notwithstanding general statements in the law about protecting confidentiality of patients' health information, there are infringements of said confidentiality. Concern about loss of confidentiality, including providing information to law enforcement that can result in prosecution for administrative or criminal offences, is an obvious disincentive to seeking treatment. The national expert group has recommended that the government organize and support a network of sites providing greater access to drug dependence treatment that is voluntary, free and anonymous.

In addition, for people receiving drug dependence treatment, there are unjustifiably broad exceptions in current Kyrgyz law to the general requirement of maintaining medical confidentiality of patients — including disclosure of patient information to law enforcement bodies upon request. The experts note that confidentiality of medical information, including information about narcological diagnosis in Kyrgyzstan is too frequently disregarded. To protect confidentiality better, legislative provisions such as the following should be added to the *Law "On narcotic drugs, psychotropic substances and precursors"* and/or to the new law on drug dependence prevention and treatment recommended by the national expert group (see Recommendation 12 below):

Confidentiality of patients' information

(1) The confidentiality of all health care information shall be respected. Records of the identity, diagnosis, prognosis or treatment of any patient which are created or obtained in the course of drug dependence treatment:
(a) are confidential;
(b) are not open to public inspection or disclosure;
(c) shall not be shared with other individuals or agencies without the consent of the person to whom the record relates; and
(d) shall not be discoverable or admissible during legal proceedings.

(2) No record referred to in Section (1) may be used to
(a) initiate or substantiate any criminal charges against a patient; or
(b) act as grounds for conducting any investigation of a patient.

(3) Programme staff cannot be compelled under the *Criminal Code* or any other law to provide evidence concerning the information that was entrusted to them or became known to them in this capacity.

(4) All use of personal information of patients and programme staff in research and evaluation shall be undertaken in conditions guaranteeing anonymity, and any such information shall also be governed by Section (2) of this article.

Recommendation 12: Adopt a new law on drug dependence prevention and treatment

The national expert group has recommended that Kyrgyzstan draft and adopt a new *Law "On drug dependence prevention and treatment"*, which would provide a legal basis and guarantees of safety for the activities of medical staff, social and outreach workers, their rights and duties, and mechanisms for the protection of the rights of patients from stigmatization and discrimination. After the law is drafted it is recommended to remove relevant articles and the chapter on drug dependence treatment from the *Law*

"On narcotics, psychotropic substances and precursors" (Chapter VI) that references prevention and treatment of drug dependence. All questions connected with prevention and treatment of drug dependence treatment would be found in the separate law directed at prevention of dependence and reducing harms associated with drug use (e.g., prevention of HIV among other things).[954]

Whether in a new law on drug dependence treatment or by amendment to existing legislation, the government should include provisions such as the following to ensure drug dependence treatment is done in accord with good practice and human rights norms:

Basic rights of patients

Every patient has the right:

(a) to a full course of high-quality treatment and follow-up support to be provided in accordance with good clinical practice;
(b) to treatment without discrimination;
(c) to meaningful participation in determining his or her own treatment goals, which may include but are not limited to abstinence or changes in drug use that minimize the harms of dependence;
(d) to meaningful participation in all treatment decisions, including when and how treatment is initiated and withdrawal from treatment;
(e) to exercise his or her rights as a patient, including:
  (i) reporting, without retribution, any instances of suspected abuse, neglect, or exploitation of patients in the programme;
  (ii) a grievance and appeal process, in accordance with national laws and regulations;
  (iii) input into the policies and services of drug dependence treatment programmes; and
  (iv) voluntary withdrawal from treatment at any time.
(f) to confidentiality of medical records and clinical test results; and
(g) to be fully informed, including but not limited to the right to receive information on:
  (i) his or her state of health;
  (ii) his or her rights and obligations as a patient, as specified in this Part and in applicable law;
  (iii) the procedure for making a complaint about the services received through the programme; and
  (iv) cost and payment conditions and the availability of medical insurance and other possible subsidies.

Informed consent

(1) Informed voluntary consent of a patient is a necessary preliminary condition for medical treatment or a preventive or diagnostic intervention.

(2) The following are the elements required for consent to treatment:
  (a) the consent must relate specifically to the treatment administered;
  (b) the consent must be fully informed;
  (c) the consent must be given voluntarily;
  (d) the consent must be provided in writing; and
  (e) the consent must not be obtained through misrepresentation or fraud.

(3) A consent to treatment is fully informed if, before giving it:
  (a) the person received the information about the matters set out in Section (4) that a reasonable person in the same circumstances would require in order to make a decision about the treatment; and
  (b) the person received responses to his or her requests for additional information about those matters.

(4) The matters referred to in Section (3) are:
  1. The nature of the treatment.
  2. The expected benefits of the treatment.
  3. The material risks of the treatment.
  4. The material side effects of the treatment.
  5. Alternative courses of action.
  6. The likely consequences of not having the treatment.

Withdrawal from treatment

(1) A patient shall have the right to withdraw voluntarily from treatment at any time.

(2) The health practitioner shall fully inform the patient of the potential risks and benefits of withdrawal from treatment and shall work with the patient to ensure the patient's safety and comfort during the withdrawal process.

(3) The health practitioner shall not discontinue services that are needed unless the patient requests the discontinuation, alternate services are arranged, or the patient is given a reasonable opportunity to arrange alternate services.

(4) The withdrawal from treatment with an explanation of likely consequences shall be recorded or registered in medical documentation and signed by the patient and health practitioner.

(5) Involuntary withdrawal from treatment shall be avoided except where compelling reasons exist. Regulations governing grounds for involuntary withdrawal shall be clearly communicated to patients at the outset of treatment.

Recommendation 13: Address overdose among people who use drugs

According to the information presented by the experts, Kyrgyzstan is one of the few countries of the region where naloxone is included in the national list of essential medicines. However, even in Kyrgyzstan this medicine is not allowed to be distributed by outreach workers. The national expert group has recommended that medical personnel and outreach NGO workers receive training in diagnosing and providing emergency treatment for overdose. Consideration should also be given to making naloxone, and information on its use to reverse overdoses, available to outreach workers from harm reduction programmes and to people who use opioids or whose acquaintances are at risk of overdose.

Recommendation 14: Developing legal regulation of outreach work

According to the national expert group, the activities of outreach workers are not legally regulated, meaning the standards, rules and conditions of their activity are not defined, nor are there guarantees of legal and social protection, putting them at risk of legal liability. Some legislative provisions that could usefully address this concern are as follows:

Outreach to people who use drugs

(1) "Outreach work" means a community-oriented activity undertaken to contact and provide information and services to individuals or groups from particular populations at risk of blood-borne diseases, particularly those who are not effectively contacted or reached by existing information and services or through traditional health care channels.

(2) "Outreach workers" include paid social or public health workers or unpaid volunteers (including peers) of governmental or non-governmental facilities.

(3) Outreach workers may include people who currently use drugs, people who formerly used drugs or people who do not use drugs and are trusted by people who use drugs.

954 For more detailed model statutory provisions for a new law on drug dependence treatment, see *Legislating for Health and Human Rights: Model Law on Drug Use and HIV/AIDS* (Toronto: Canadian HIV/AIDS Legal Network, 2006), and in particular Module 2: Treatment for drug dependence.

Supply of information

Outreach workers may provide information including, but not limited to, the following:

(a) drug dependence treatment services and other health services;
(b) means of protection against transmissible diseases, including blood-borne diseases such as HIV;
(c) the risks associated with the use of controlled substances;
(d) harm reduction information specific to the drug being used, including safe injecting and inhaling practices;
(e) legal aid services;
(f) employment and vocational training services and centres; and
(g) available support services for people with drug dependence and their families.

Supply of material

Outreach workers may provide the following materials:
(a) sterile syringes and other related material for safer injection drug use, including sterile water ampoules, swabs, filters, safe acid preparations, spoons and bowls and other appropriate materials;
(b) material to enable safer smoking and inhalation of drugs, such as pipes, stems, metal screens, alcohol wipes and lip balm;
(c) condoms and other safer sex materials such as water-based lubricants and dental dams, as well as information about reducing the risks of HIV and other sexually transmitted infections; and
(d) first aid in emergency situations.

Exemption from criminal and civil liability for outreach work

(1) The *Law "On narcotic drugs, psychotropic substances and precursors"* does not prevent the giving of advice, information or instruction for safer drug consumption practices by outreach workers nor does it prohibit the sale or supply of syringes and other related material by outreach workers.

(2) A civil proceeding cannot be brought against any person (including the state or outreach staff) in relation to any act or omission in connection with outreach work, if the act or omission was in good faith for the purpose of executing this Part and was not a reckless or negligent act or omission.

Recommendation 15: Limit the use of involuntary HIV testing

If HIV testing is ever to be imposed without consent, then it requires a process clearly set out in law, with a requirement that such measures be taken only in exceptional circumstances and with adequate justification that must be considered by an independent, judicial body, and with the most limited infringement of human rights possible.[955]

The *Law "On HIV/AIDS"* currently provides for mandatory HIV testing for blood, organ and tissue donors; foreigners and stateless persons when provided by international bilateral agreement; and people occupied in specific professions, defined by a special list (adopted by the Government of Kyrgyzstan).[956] According to international standards, mandatory HIV testing is justified only in case of blood, organ or tissue donors. Thus, the *Law "On HIV/AIDS"* should be amended to prohibit obligatory HIV testing except in such cases, and should explicitly prohibit mandatory testing as an employment requirement or as a residence/entry requirement for foreigners or stateless persons. Adding a legislative provision such as the following would be advisable:

955 Guidelines such as the UN's *Siracusa Principles* on permissible limitations on human rights should be complied with in any legislative provision that would allow involuntary testing or treatment: UN Economic and Social Council, *Siracusa Principles on the Limitation and Derogation Provisions in the International Covenant on Civil and Political Rights*, UN Doc. E/CN.4/1985/4, Annex (1985).

956 *Law "On HIV/AIDS in Kyrgyzstan"*, Article 8.

Voluntariness of HIV testing

(1) Every person is entitled to free confidential [or anonymous] testing for infection with HIV, other blood-borne infections or other sexually transmitted infections, and to counselling in connection with such testing.

(2) No test for HIV, other blood-borne infection or other sexually transmitted infection shall be undertaken except with the informed voluntary consent in writing of the person being tested.

(3) All persons presenting themselves for testing shall be offered pre-test and post-test counselling by a health practitioners, in accordance with professional standards.

Prisons

Recommendation 16: Develop and monitor indicators on drug use in prisons

The national expert group has recommended establishing a working group of employees of the correctional system of Kyrgyzstan to develop indicators for the regular collection of the information on prevalence of drug use among prison population.

Recommendation 17: Provide information about HIV prevention in prisons

To enhance HIV prevention efforts in prisons, the Internal Regulations of correctional facilities[957] (para. 3) should be amended to mandate that newly arrived prisoners receive information on HIV prevention and treatment during the first several days of stay in prison.

Recommendation 18: Voluntary drug dependence treatment in prisons

As part of an effective response to HIV and otherwise promoting the health of prisoners, Ministry of Justice, in collaboration with the Ministry of Health and with non-governmental organizations should draft and adopt an "Instruction on the procedure and conditions of free narcological assistance in the correctional system."

Recommendation 19: Limit application of compulsory medical treatment in prisons

In order to better protect human rights, it is recommended to review provisions on compulsory treatment in prisons. The *Penal Code* provides, that compulsory treatment is applied to those with drug dependence, HIV infection, active tuberculosis, and those who have not completed a full course of treatment of a venereal disease. The scope of compulsory treatment should be narrowed.

Recommendation 20: Eliminate discrimination against HIV-positive prisoners, including segregation, and against prisoners with drug dependence

Current Kyrgyz law includes a number of provisions that unjustifiably discriminate against prisoners based on HIV-positive status and/or drug dependence. To eliminate such discrimination, the following amendments to the *Penal Code* are required:

- Article 68 of the *Penal Code* of the Kyrgyz Republic prohibits movement without an escort or convoy outside the protected territory for a number of categories of prisoners, including those who have not finished complete course of compulsory treatment of alcohol or drug dependence, open

957 Ministry of Justice, *Internal rules of the penitentiary institutions of the Ministry of Justice of the Kyrgyz Republic* [Правила внутреннего распорядка исправительных учреждений Министерства юстиции Кыргызской Республики], No. 164 (28 October 2003).

form of tuberculosis, STI or prisoners with HIV. This should be repealed or narrowed.
- Articles 69 of the *Penal Code* of the Kyrgyz Republic does not allow short-term leaves from the correctional facilities in cases of personal emergencies of the same categories of prisoners. It, too, should be repealed or narrowed.

In addition, the current segregation of prisoners based on HIV status is unjustified discrimination and contrary to international, human rights-based recommendations. This policy and practice should be eliminated in Kyrgyzstan, through amendments to the following:

- *Penal Code of the Kyrgyz Republic* (Articles 17, 48, 68, 69, 73);
- *Law "On the order and conditions of holding persons in custody detained on suspicion or charges with a crime"* (Article 31);
- "Internal Regulations for correctional facilities of the Ministry of Justice of the Kyrgyz Republic" (paragraph 3); and

"Regulations of pre-trial detention facilities of the Ministry of Justice of the Kyrgyz Republic" (paragraph 38).

Discrimination and restriction of rights

Recommendation 21: Eliminate discrimination in employment based on HIV status

Currently, the Constitution has a very broad prohibition on discrimination, and the *Law "On HIV/AIDS"* prohibits unreasonable refusal to employ, or unreasonable dismissal of, people with HIV or AIDS. This is consistent with international human rights law, and is a welcome feature in Kyrgyz law. Yet the Government of Kyrgyzstan has also adopted a list that restricts people from working in certain trades or occupations based on HIV-positive status, which amounts to discrimination that can rarely be justified.[958] To rectify this inconsistency, and to protect better the rights of people living with HIV, two steps can be taken:

- First, the Government should review the existing list and other official government documents that include HIV on a list of diseases that preclude a person from holding certain positions, and amend them to remove any reference to HIV unless there is a clear, scientifically sound basis establishing that performing such employment cannot be done without posing a significant risk to the health of another person. Such will very rarely be the case — to the point that it would also be entirely possible simply to abolish the list entirely, and if the Ministry of Health needed to develop some specific guidelines or rules to handle the very exceptional cases in a particular kind of work, this could be done; taking a much narrower approach would avoid the overly-broad and discriminatory approach of the current list.

- Second, a legislative amendment to the *Law "On HIV/AIDS"* should be added that could be worded as follows:

> Discriminating against a person on the basis of his or her actual or perceived HIV infection or AIDS diagnosis [or on the basis of other blood-borne infection] is prohibited, including but not limited to such contexts as employment [or education]. It is unlawful discrimination to require that a person be tested for HIV as a condition of employment [or enrolment in an educational institution], either before or during employment [or enrolment].

Recommendation 22: Eliminate discrimination against drug-dependent persons in educational and employment settings

According to the information presented by the national expert group, upon enrolment to certain courses of higher educational institutions, the applicants need to undergo general physical examination, which includes narcological testing. For example, persons applying for enrolment to military schools must pass a physical examination, including proof of absence of narcological disease.[959] Government guidelines also authorize drug testing of secondary school students.[960] However, requiring such testing, and denying enrolment in an educational institution based on a positive drug test (and presumed drug dependence), is unjustifiable discrimination, as well as a violation of privacy rights and security of the person. These instruments should be should be repealed.

Discrimination based on real or perceived drug dependence is also of concern in the employment context. Requiring drug testing *before* employment is unjustified discrimination based on health condition. Requiring testing for drug use *during* employment may only be potentially justifiable in quite limited circumstances, such as limiting testing to positions that are safety-sensitive and then only in cases where there are reasonable grounds to suspect impairment or possibly random drug testing of persons returning to work after receiving treatment for drug dependence.

- It is recommended to begin a consultation process with policy-makers and to study experiences of other countries for models of legislation that limits restrictions on permitted occupations based on drug use only in specific cases defined in the law and based on individual assessments of ability to perform.

- Provisions in the *Law "On narcotic drugs, psychotropic substances and precursors",* and in the national anti-drug programme, that encourage or permit workplace drug testing in overly broad circumstances should be eliminated.

- Instead, it is recommended that Kyrgyz law (e.g., the *Law "On narcotic drugs, psychotropic substances and precursors"*) be amended to include a provision along the lines of the following:[961]

> **Discrimination based on drug use**
>
> (1) Absent a reasonable justification given the circumstances of the case, it is prohibited to discriminate against a person, or a relative or associate of the person, on the ground that the person uses or has used drugs, or is perceived to use or have used drugs.
>
> (2) It is unlawful discrimination to require that a person undergo drug testing as condition of enrolment in an educational institution, either before or during enrolment.
>
> (3) It is unlawful discrimination to require that a person undergo drug testing as a pre-condition of employment. Making drug testing a condition of continued employment is permitted only in positions, as designated by [suitable government authority], where impairment while at work may pose a significant risk of harm to the individual employee or to others *and* where there are reasonable grounds to suspect that the individual employee may be impaired by drug use.

Recommendation 23: Respect and protect family relationships

Relevant legislation should be amended to clarify that, in cases of concern about child abuse or neglect, drug dependence should not be assumed to be *per se* sufficient grounds to deprive someone of parental rights, but rather a careful analysis of the individual circumstances is required.

958 E.g., see UNAIDS/OHCHR, *International Guidelines on HIV/AIDS and Human Rights*, para. 149. Similar analysis would apply to discrimination against someone based on something like infection with hepatitis B or C virus (HBV, HCV) or on the basis of a sexually transmitted infection. Given modes of transmission, many people who inject drugs are vulnerable to infection with other blood-borne diseases such as HBV or HCV, in addition to HIV, and may face discrimination on that basis, as has been observed in other jurisdictions. In making amendments to strengthen protection against HIV-related discrimination in an area such as employment or educational contexts, it would be advisable to include explicit protection against discrimination based on such other diseases.

959 "Instruction on physical examination of students and candidates seeking admission to military schools" [Инструкция о порядке проведения профилактического медицинского обследования в образовательных учреждениях Кыргызской Республики на предмет выявления несовершеннолетних лиц, допускающих потребление наркотических и психотропных веществ], No. 199 (9 September 2000).

960 "Instruction on the order for the preventive medical examination in educational institutions of the Kyrgyz Republic to detect minors consuming narcotic and psychotropic substances," No. 468/662/1 (15 November 2002).

961 See *Legislating for Health and Human Rights: Model Law on Drug Use and HIV/AIDS*, Module 7: Stigma and discrimination, pp. 13-15.

TAJIKISTAN

SUMMARY REPORT AND RECOMMENDATIONS

TAJIKISTAN: SUMMARY REPORT AND RECOMMENDATIONS

1. BACKGROUND

As a result of its geographical position (bordering Afghanistan, China and the other Central Asian republics of Uzbekistan and Kyrgyzstan) and its unstable social and economic situation, Tajikistan has become a transit corridor for narcotics destined for other countries, meaning that narcotics are also easily accessible and cheap in Tajikistan itself, contributing to their use, including in ways that risk transmission of HIV and other blood-borne diseases. Additional drivers of the HIV epidemic in Tajikistan include high levels of labour migration and low levels of HIV awareness among the population as a whole, with risky activities a consequence, especially among young, such as initiating drug use and engaging in unsafe sex.[962]

According to UNAIDS, the estimated number of people living with HIV in 2007 was 10,000 (within a range of 5,000 to 23,000).[963] As of April 2008, 1153 cases of HIV infection had been officially registered in Tajikistan by health officials, of which 17.5% were among women. Of the total number of HIV infections, according to official data, 57.5% (663) were attributable to infection through injection drug use, while 23.7% (274) were thought to have been acquired through sexual contact.[964]

One source estimates that some 15,000 people inject drugs in Tajikistan, of which 23.5% have HIV and 43.4% have hepatitis C virus (HCV).[965] According to more recently published data, there are estimated 17,000 people in Tajikistan who inject drugs, which represents a prevalence of injecting drug use of 0.45 % (among adults between the ages of 15 and 64).[966] The number of officially-registered drug users has risen from 4,200 in 2000 to 8,607 in 2007.[967] Older official data indicated that, as of January 2005, there were 9,134 people with drug addiction officially recorded by Tajik authorities; according to government sources, this figure represents only those who had voluntarily applied for narcological assistance. Official estimates suggest that the number of persons who have applied for narcological assistance represents but one-tenth of the actual number of those with drug dependence.[968] Since 2001, there has been a sharp increase in the number of persons injecting drugs, now estimated at 49% of the total number of people who use drugs in one way or another (of which 97% are men).[969] HIV prevalence among people who inject drugs has been estimated at 14.7 %.[970] In 2006, HIV prevalence among injecting drug users in the capital city, Dushanbe, was estimated at 23.5 %.[971]

According to the information provided by national experts, as of 2008, 118 people in the country were receiving antiretroviral (ARV) treatment. In Tajikistan, there is one national centre on HIV prevention, as well as four provincial, seven district, and three city centres. In 2007, Tajikistan's prison population included a total of 139 prisoners with diagnosed HIV and 752 prisoners with diagnosed tuberculosis. HIV prevalence in penitentiary institutions was 6.2%, while HCV prevalence was 24.3%.[972] According to other estimates, HIV prevalence among prisoners is as high as 8.4%.[973] According to official information, of the total number of people living with HIV in Tajikistan, 70% are people who inject drugs and 21% of them are imprisoned.[974]

962 See the preamble to the "Program on prevention of distribution of narcotic addiction and improvement of narcological assistance in the Republic of Tajikistan for 2005-2010".

963 UNAIDS, *2008 Report on the global AIDS epidemic* (Geneva, 2008), Annex 1.

964 Statistics provided by national expert group in detailed country report (available in Russian only).

965 International Harm Reduction Association, *Global State of Harm Reduction 2008: Mapping the Response to Drug-related HIV and Hepatitis C Epidemics* (London: IHRA, 2008), page 34.

966 B. Mathers et al., "Global epidemiology of injecting drug use and HIV among people who inject drugs: a systematic review", Lancet 2008; 327 (24 September), doi:10.1016/S0140-6736(08)61311-2, online in full via website of Reference Group to the United Nations on Injecting Drug Use and HIV, www.idurefgroup.unsw.edu.au/IDURGWeb.nsf/page/publications.

967 United Nations Office on Drugs and Crime, Regional Office for Central Asia, Compendium of Drug-Related Statistics 1997-2008, June 2008, p. 29.

968 See the preamble to the "Program on prevention of distribution of narcotic addiction and improvement of narcological assistance in the Republic of Tajikistan for 2005-2010".

969 *Ibid*., p. 10.

970 United Nations Office on Drugs and Crime, Regional Office for Central Asia, Compendium of Drug-Related Statistics 1997-2008, June 2008, p. 29.

971 UNAIDS, *2008 Report on the global AIDS epidemic* (Geneva, 2008), Annex 1.

972 Information provided by the national expert group.

973 International Harm Reduction Association, *Global State of Harm Reduction 2008: Mapping the Response to Drug-related HIV and Hepatitis C Epidemics* (London: IHRA, 2008), p. 38.

974 "*Program on counteracting HIV/AIDS epidemics in the Republic of Tajikistan 2007-2010*", Government Resolution NO. 86 (3 March 2007).

2. NATIONAL PROGRAMMES AND STRATEGIES

Programmes on HIV/AIDS

In 1997, the national government created the National Coordinating Committee (NCC) on prevention and control of HIV/AIDS, tuberculosis and malaria which includes NGOs working with people with drug dependence and people living with HIV (PLHIV).[975] In the same year, the government adopted the "National Programme for Prevention and Control of HIV, AIDS and Sexually Transmitted Diseases in the Republic of Tajikistan, 1997-2007". At the end of this 10-year programme, the national government adopted the new "Programme on Counteracting the HIV/AIDS Epidemic in the Republic of Tajikistan, 2007-2010", which includes explicit attention to preventing HIV infection among people with drug dependence, sex workers, youth, migrants, and prisoners, as well as efforts to secure the safety of donated blood.[976] Among other measures, the programme mentions: establishing needle and syringe programmes (NSPs), including mobile NSPs, to be delivered by NGOs; implementing programmes providing opioid substitution therapy (OST); and training on interventions in cases of overdose. Development of the programme was based on a situation analysis by the Ministry of Health in collaboration with other ministries and departments and non-governmental organizations, with the assistance of the national UNAIDS Theme Group and other international organizations.[977] These initiatives reflect measures already contemplated in the Ministry of Health's own "Strategic Programme on Counteracting the HIV/AIDS Epidemic in Tajikistan for the period 2004-2010", which programme includes activities aimed at HIV prevention among people who use drugs, sex workers, youth, migrants and prisoners, and also makes explicit reference to implementing NSPs (including mobile programmes conducted by NGOs), opioid substitution therapy and overdose prevention programmes.

Programmes on narcotic drugs

In 1996 and 1999, Tajikistan launched two national programmes to control narcotics; however, some of the activities remained largely declarative, as neither programme contained any provisions for financing and no budget was developed. The decisive and supervising role in the development of the programmes belonged to the Drug Control Agency.[978] Aside from law enforcement measures as a strategy for preventing drug use, the drug control programmes were limited to activities aimed at increasing awareness of the general population and youth about drug abuse, and organization of various expert round tables. There were some provisions concerning narcological treatment, such as supplying medical institutions with equipment and expertise, and measures aimed at enhancing the narcological service's system of registering drug-dependent persons and its interaction with law enforcement bodies. Neither programme mentioned measures aimed at reducing harms associated with the use of illegal drugs.

The national expert group has reported that the national government has recognized the limitations of the law enforcement approach to the prevention and treatment of narcotics addiction, and of the involvement of the Drug Control Agency in medical fields, and has accordingly decided to adjust its national strategy. In April 2005, the Republic of Tajikistan approved the "Programme on Preventing Narcotic Addiction and Improving Narcological Assistance in the Republic of Tajikistan, 2005-2010".[979] As the name suggests, this programme has a medical focus, rather than mixing law enforcement objectives with the treatment of narcotic addiction.

This programme includes activities in areas categorized as "primary prevention" (aimed at preventing the first use of drugs), "secondary prevention" (treatment and rehabilitation programmes to address drug dependence) and "tertiary prevention" (aimed at preventing relapse into drug use following intervention). The programme's preamble refers to elements of a harm reduction approach (e.g., the supply of sterile injection equipment), and explicitly notes that a major objective, in addition to preventing drug dependence, is the "prevention of HIV/AIDS transmission through non-sterile tools used during intravenous drug use". The programme also seeks to review and improve the existing legislation in this area, improve the structure of the state narcological institutions and their relations with the AIDS centres and the non-governmental sector's health and social services. Priorities include comprehensive programmes of harm reduction.

According to the national expert group, this programme has not been fully implemented on time. However, in 2006 the Ministry of Health approved an order "On the improvement of narcological assistance in the Republic of Tajikistan",[980] which assigns new functions to the narcological service, including the realization of narcological assistance based on harm reduction methods, including the implementation of opioid substitution treatment. According to the national expert group, introducing the approved standards of narcological assistance will require both a substantial increase in the annual budget of the narcological service and significant investments to reorganize it and equip it with materials and personnel. The programme does not define the sources and size of financing, simply mentioning "state funding" and "grants of international organizations".

To promote the success of these programmes, the national expert group has recommended: creating and strengthening monitoring mechanisms to track performance and the efficiency of measures adopted; accurately developing the budget to support these programmes; and clearly identifying those responsible for implementation. The national expert group has also recommended the active involvement of civil society in the implementation and monitoring of the programmes.

975 See: http://www.ncc.tj//index.php?option=com_frontpage&Itemid=68.

976 Government of the Republic of Tajikistan, Resolution No.86 (3 March 2007).

977 In addition to the programs described above, the national government has approved both the "National program for prevention and control of hepatitis B in the Republic of Tajikistan, 2000-2007" (Order No. 100, 11 March 2000) and the "National program against tuberculosis in the Republic of Tajikistan, 2003-2010" (Order No. 524, 31 December 2002).

978 According to the *Law on narcotic drugs, psychotropic substances and precursors*, Law No. 873/874 (10 December 1999), the "Agency is a law enforcement body which co-ordinates and supervises activity of the state bodies on licit turnover of narcotics, psychotropic substances and precursors, trafficking of these substances, the prevention of addiction to narcotics and other toxins, and social rehabilitation for drug addicts and toxic addicts" (para. 5). Thus this document obliges the national drug control agency (which reports directly to the President) to co-ordinate the work of all ministries and departments in these areas.

979 Government Resolution No. 113 (2 April 2005).

980 Ministry of Health of the Republic of Tajikistan, "*On improving narcological assistance in the Republic of Tajikistan*", Order No. 485 (7 August 2006).

3. ADMINISTRATIVE AND CRIMINAL LAW PROVISIONS ON NARCOTIC DRUGS

Prohibition on drug use but without penalty

Consumption of narcotics *per se* is neither a crime nor an administrative offence under Tajik law. Article 15 of the 1999 *Law on narcotics, psychotropic substances and precursors* states that the consumption of narcotics and psychotropic substances without a prescription from a medical doctor is prohibited. However, there is no penalty prescribed, and neither the *Administrative Code* nor the *Criminal Code* addresses this issue.

In 2004 the Criminal Code of Tajikistan was amended to significantly increase in the minimum quantity of substance leading to criminal charges, thus placing Tajikistan among countries with more progressive drug policies in the post-Soviet region.

TABLE: Reforms to Tajikistan's criminal laws on drugs[981]

Criminal Code of Tajikistan before the reform (1998)			New Criminal Code (2004)	
Substance	Quantity	Penalty	Quantity	Penalty
Heroin	0.015-0.15 g	Prison sentence of 5-10 years with confiscation of property	0.5-10 g	Prison for up to 5 years
Opium	0.15-1 g		5-10 g	
Hashish	0.1- 10 g		100-200 g	
Heroin	0.15-1.5 g	Prison sentence of 12-15 years with confiscation of property	10-100 g	Prison for 5-8 years with confiscation of property
Opium	1-10 g		100-1000 g	
Hashish	10-100 g		200-1000 g	
Heroin	> 1.5 g	Prison sentence of 15-20 years with confiscation or capital punishment	100-1000 g	Prison for 8-12 years with or without confiscation of property. Capital punishment abolished.
Opium	> 10 g		1 kg – 10 kg	
Hashish	> 100 g		1 kg – 10 kg	

Administrative offences

The *Code of the Republic of Tajikistan on Administrative Responsibility* ("*Administrative Code*") makes it an administrative offence to illegally manufacture, produce, process, acquire, possess, transport or transfer narcotics *without an intention to sell*. The penalty for such administrative offences is a fine ranging from 12 to 30 times the official minimum wage.[982] Administrative liability applies only when the quantity of narcotic or psychotropic substance falls below the threshold of the "small" [мелкие] amount that triggers criminal liability (see below). The quantity of a narcotic or psychotropic substance required to trigger criminal liability (e.g. 0.5g in the case of heroin) is higher than comparable thresholds set in the law of neighbouring republics, making Tajik law the most liberal, in this regard, of the countries of the former Soviet Union.[983]

Criminal offences

Tajikistan's *Criminal Code* establishes criminal liability for the following acts with the possible penalties (including minimum penalties in some cases) as indicated:[984]

981 Murtazokul Khidorov, Maiya An, "Human rights through the lens of drug dependence in Tajikistan" in Kasia Malinowska-Sempruch, Sarah Gallagher *War on Drugs, HIV/AIDS and Human Rights* (Russian edition), International Debate Education Association, 2006. p 191.

982 *Code of the Republic of Tajikistan on Administrative Responsibility*, Article 42(1).

983 See appendix for the table on quantities of substances.

984 Criminal liability for drug offences can be applied as of the age of 14: *Criminal Code of the Republic of Tajikistan*, Law No. 684 (13 November 1998), Article 23. (The *Criminal Code* was last amended by Law No. 97 on 25 July 2005.) Administrative liability can be imposed as of the age of 16: *Code of the Republic of Tajikistan on Administrative Responsibility*, Law No. 32 (10 May 2002), Article 12. (The *Administrative Code* was last amended on 18 July 2008).

- illicit distribution of narcotic drugs and psychotropic substances, *without an intention to sell*, in
  - "small" quantities (a fine or up to two years' imprisonment);
  - in "minor" quantities (two-five years' imprisonment);
  - as a repeat offence, by an organized group, in prisons, using an official capacity, or in large quantities (five-eight years' imprisonment with or without confiscation of property); or
  - in "extra large quantities" (eight-12 years' imprisonment with or without confiscation of property).[985]
- manufacturing, producing, processing, acquiring, possessing, transporting or transferring narcotics and psychotropic substances, *with an intention to sell*,
  - in "small" [мелкие] quantities (up to five years' imprisonment);
  - in "minor" quantities [небольшие] (five-eight years' imprisonment);
  - as a repeat offence, in schools, or by an organized group (8-12 years' imprisonment, with or without confiscation of property); or
  - in prisons or in "large quantities" (12-20 years' imprisonment with confiscation of property);[986]
- theft of narcotic drugs and substances (three-15 years' imprisonment);[987]
- illicit distribution of precursors (a fine or from two to eight years' imprisonment, depending on quantity)[988]
- "involving" other persons in the consumption of narcotics or psychotropic substances (imprisonment for up to five years), or involvement of another person with aggravating circumstances (e.g., in relation to a minor, involving two or more persons, using violence, as a repeat offence, in prisons, or by an organized group) (three to five years' imprisonment);[989]
- illicit cultivation of prohibited plants containing narcotic substances (a fine or up to 12 years' imprisonment);[990] and
- organizing or maintaining "sites" for the consumption of narcotics or psychotropic substances (three to ten years' imprisonment).[991]

As noted above, the possession of quite small amounts of a prohibited drug without an intention to sell — *de facto*, possession for personal use only — amounts to an administrative offence under the *Administrative Code*. Once the amount reaches a certain threshold, it may trigger criminal liability. While Tajikistan's *Criminal Code* does not explicitly recognize the concept of possession of narcotic substances "for personal consumption", it does provide for lesser penalties in the case of first offences involving small quantities of prohibited drugs where the activity is done "without intention to sell": possession or other activities involving "small" amounts of narcotics (the amounts are defined in schedules adopted by a Government resolution), and without the intention to sell, attracts a fine as the minimum penalty for a first offence.[992] However, subsequent offences of this sort are punished quite harshly: subsequent convictions can attract a mandatory minimum sentence of imprisonment from five to eight years (even for small amounts of drugs). In addition, a court may order the confiscation of property in the event the offence is committed with aggravating circumstances — indeed this penalty is applied as a general rule in the presence of aggravating circumstances, such as a repeat offence, an offence committed by an organized group or someone in an official capacity, an offence committed in a prison, or an offence involving large quantities of the prohibited substance.[993] Being under the influence of drugs at the time of an offence is not an aggravating circumstance, which is a welcome feature in contrast with the laws of several other countries in the region.

Needle and syringe programmes: legal issues

Needle and syringe programmes (NSPs) operate in Tajikistan, although the country has not yet developed or approved official procedures for such programmes. Tajik law does not limit the sale of needles and syringes in pharmacies, nor is the possession of drug paraphernalia a criminal offence. However, the

985 *Criminal Code*, Article 201.

986 *Criminal Code*, Article 200.

987 *Criminal Code*, Articles 202.

988 *Criminal Code*, Articles 202(1).

989 *Criminal Code*, Articles 203. The term "involvement" is not defined.

990 *Criminal Code*, Articles 204.

991 *Criminal Code*, Article 205.

992 *Criminal Code*, Article 201.

993 *Criminal Code*, Articles 200-204.

national expert group notes that, in theory, NGOs that implement NSPs could potentially be liable under provision on "involvement" in the consumption of narcotics (*Criminal Code*, Article 203) or organizing a site for drug consumption (*Criminal Code*, Article 205). The national expert group recommends that the law be clarified to exclude the activities of personnel of NSPs — which activities are conducted with a view to preventing HIV and other blood-borne infections among people who use drugs — from the scope of potential legal liability.

Compulsory drug testing, including by law enforcement

Tajikistan's *Law "On narcotic drugs, psychotropic substances and precursors"* has an extremely wide provision aimed at detecting those who consume narcotic substances: "if there are sufficient grounds [достаточные основания] to believe that a person has consumed illegal narcotics or psychotropic substances, s/he shall be subject to physical examination in narcological institutions of the Ministry of Health."[994]

The *Law "On narcological assistance"* further expands that legislation and limits the rights of persons, beyond the criminal law context: "Where there are grounds to believe that a person suffers from drug dependence, alcoholism, is under the influence of alcohol or narcotics, or has used a narcotic or psychotropic substance without a prescription from a medical doctor, the person may be referred for physical examination."[995]

Law enforcement bodies, following the procedure established by law, take persons suspected of committing crimes connected with narcotics or psychotropic substances for such examination, with a view to establishing the use of narcotics or psychotropic substances.

However, such wide provisions on compulsory drug testing, vesting such extensive powers in law enforcement bodies, represent not only an inefficient use of limited resources but also an unjustified intrusion on human rights. For example, subjecting someone who has not committed any offence to involuntary drug testing violates the rights to liberty, security of the person and privacy, as well as the right to be free from non-consensual medical intervention; if test results are also used against the person in any sort of prosecution, it would also violate the right against self-incrimination.[996] The only possible bases on which it might be justifiable for the state to infringe such human rights would be to intervene to prevent a serious risk of harm to oneself or to others; mere use of alcohol or drugs does not, by itself, establish this.

Groups at higher risk of HIV: criminal and administrative law issues

Sex work:

According to the *Administrative Code* of Tajikistan, prostitution is an administrative offence and leads to a warning or fine in the amount of ½ of one monthly minimal wage. Repeated offence committed within the same year leads to a higher fine of 2 minimal monthly wage.[997]

Article 238 of the *Criminal Code* criminalises "involvement" in prostitution using force, coercion or threats. Article 239 provides for criminal liability for organising and maintenance of brothels or pimping, which is punishable by fine, or imprisonment for up to five years.[998]

The *International Guidelines on HIV/AIDS and Human Rights* recommend that "with regard to adult sex work that involves no victimization, criminal law should be reviewed with the aim of decriminalising and legally regulating occupational health and safety conditions to protect sex workers and their clients, including support for safe sex during sex work".[999] Criminalizing sex work and sex workers contributes to their further stigmatization and marginalization, putting them at greater risk of human rights abuses and exacerbating vulnerability to HIV. It is recommended to repeal Article 174.1 of the *Administrative Code* of Tajikistan. Articles 238-239 of the Criminal Code are sufficient for punishing criminal behaviour in relation to sex work.

994 *Law "On narcotic drugs, psychotropic substances and precursors"*, No. 874 (10 December 1999), Article 16.

995 *Law "On narcological assistance"*, No.67 (8 December 2003), Article 18.

996 *International Covenant on Civil and Political Rights*, 999 U.N.T.S. 171 (1966), Articles 7, 9, 14, 17.

997 *Administrative Code*, Article 174.1.

998 *Criminal Code*, Articles 238-239.

999 *International Guidelines on HIV/AIDS and Human Rights*, Guideline 4, para. 21(c).

HIV and STI exposure and transmission

Article 125 of the Criminal Code of Tajikistan provides liability for:

- Knowingly exposing someone to HIV - is punishable with limitation of freedom for up to three years or imprisonment for up to two years.
- HIV transmission by person who knew of his\her infection – is punishable by imprisonment from two to five years.
- HIV transmission by someone who knew of his/her HIV infection committed in relation to two or more people or a minor – is punishable by imprisonment from five to ten years.

According to Article 126 of the Criminal Code, "transmission of veneral disease, by someone who knew of his/her disease – is punishable by fine, correctional works from one to two years, or arrest for up to six month. The same offence, committed in relation to two or more people, or a minor – is punishable by fine, imprisonment for up to two years.

Having a specific criminal offence singling out HIV exposure and negligent HIV and STI transmission, runs contrary to internationally recommended policy, in part because it stigmatizes people living with HIV, and people vulnerable to it, and creates a further disincentive for HIV and STI testing and an additional barrier to access to health services. The *International Guidelines on HIV/AIDS and Human Rights* recommend against such an approach: criminal legislation should not include specific offences regarding HIV transmission or exposure, and the scope of applying criminal law should be limited to those cases where someone acts with malicious intent to transmit HIV and does in fact transmit the virus.[1000]

1000 Joint United Nations Programme on HIV/AIDS & Office of the High Commissioner for Human Rights, *International Guidelines on HIV/AIDS and Human Rights,* Guideline 4, para. 21(a); UNAIDS, *Policy Brief: Criminalization of HIV Transmission* (2008).

4. HEALTH SYSTEM AND SERVICES

All medical services provided by the state are free of charge.[1001] Access to health services for persons with HIV or AIDS, and for those with drug dependence, is guaranteed by the state. Foreigners, including migrants and refugees, get access to medical services for the treatment of HIV/AIDS and drug dependence on an equal basis with Tajik citizens.

4A. DRUG DEPENDENCE PREVENTION AND TREATMENT

The Ministry of Health reports that the principal method of treatment for drug dependence in Tajikistan consists of short-term courses of detoxification (mainly assisted by medication). The actual success rate of the current medical treatment of heroin drug addiction does not exceed 6-8% a year (success means complete abstinence (drug free status) confirmed by periodic drug tests and medical examination performed over 12 months after completing the formal treatment course).[1002] Official documents, in particular the "Programme on preventing narcotic addiction and improving the narcological assistance in the Republic of Tajikistan, 2005-2010", have highlighted problems in the narcological assistance system.

To solve these problems, in 2006, the Ministry of Health issued an order that, among other things, sets out standards for monitoring the narcological situation in Tajikistan, establishes a series of "trust points" (points of narcological assistance in the system of HIV prevention among injection drug users), and contains a provision on narcological rehabilitation centres.[1003] The national monitoring aims to assist in planning efforts to prevent drug dependence and in evaluating the adequacy and efficiency of measures being pursued.

"Trust points" are established with the objectives of reducing HIV infection among people who use drugs and ensuring their easy access to medical aid in all treatment institutions, as well as preventing drug dependence among the population. Trust points are located within the AIDS centres, narcological clinics, and other medical institutions. HIV prevention among people who use drugs can be done by the non-governmental organizations. Trust points have the following functions:

- distributing sterile syringes, disinfectants, condoms, and information materials, as well as collecting and disposing of used syringes;
- providing information on HIV and other sexually transmitted infections (STI);
- providing social assistance, such as: help with social, legal, and housing questions; material aid; vocational training and help finding employment;
- providing counselling on HIV/AIDS, medical and social rehabilitation from drug dependence, consultations with other medical doctors and referrals for specialized medical assistance;
- providing testing for HIV, hepatitis, STIs, as well as psychological testing; and
- providing substitution therapy.

The *Law on narcological assistance* is the principal piece of legislation governing treatment of drug dependence in Tajikistan. The very fact that such a law exists is welcome — this is in contrast with several other countries in the region, where treatment of drug dependence is governed by a few articles in the national law on narcotics. At least in theory, it separates drug dependence treatment from the scope of activities of criminal law enforcement, placing it instead in the health sphere. Regulating activity connected with lawful drug distribution and counteracting illegal trafficking of narcotics remains the jurisdiction of law enforcement bodies, whereas treating drug dependence is a health activity that better fits within the jurisdiction of health authorities. (However, as noted further below, the degree to which the law requires narcological treatment providers to give information about patients to law enforcement bodies remains some cause for concern.)

1001 *Constitution of the Republic of Tajikistan* (6 November 1994), Article 38.

1002 "Program on preventing narcotic addiction and improving narcological assistance in the Republic of Tajikistan, 2005-2010", p 11.

1003 Ministry of Health, "On improving narcological assistance in the Republic of Tajikistan", Order No. 485 (7 August 2006), including Appendix No. 3: "On points of the primary narcological assistance (trust points for prevention of HIV/AIDS among injection drug users)".

Under the *Law on narcological assistance*, people who have voluntarily sought drug dependence treatment have the right to:

- free narcological assistance provided by the Ministry of Health;
- "anonymity" of treatment;[1004]
- sick leave (from employment) for the duration of a stay at a narcological centre, thereby preserving entitled to one's employment; and
- keep one's housing and employment during hospitalization at a narcological centre.[1005]

The law also provides for psychological, medical and social rehabilitation in state and non-state rehabilitation centres for persons with drug or other chemical dependencies, after a course of treatment in a narcological institution.[1006]

The law recognizes a number of rights of persons undergoing examination or treatment in a narcological centre, including:

- the right to maintain private correspondence without censorship;
- the right to receive packages and parcels;
- the right to receive visitors during set times; and
- the right to have and obtain personal articles.[1007]

These rights may be limited by the attending physician or chief physician of the institution only if absolutely necessary in the interests of health or safety of the patient or other persons.[1008] The list of rights in the legislation does not include the right to participate in making decisions about one's own health, including such basic rights as the right to appeal against a decision by the facility's administration or the right to refuse or stop treatment.

Registration of people who use drugs

Registration of people who use or are dependent on drugs is carried out in accordance with an order of the Ministry of Health[1009] and the *Law on narcological assistance*, which states that "decisions regarding the registration/deregistration of people with drug dependence or people who use drugs for non-medical purposes, are made by a commission of narcologists and psychiatrists".[1010] One area of concern is the provision on cooperation of narcological institutions with the law enforcement bodies.[1011] While the *Law on narcological assistance* specifically imposes a duty to preserve medical confidentiality with regard to narcological dependence, there are numerous, very broad exceptions: data related to a person's narcological dependence is reported, following receipt of a written inquiry, to narcological institutions, superior public health bodies, the public prosecutor, and judicial and investigative bodies.[1012] For treatment centres to provide such information to law enforcement authorities creates a potential disincentive to seeking drug dependence treatment, which hinders effective prevention and treatment of HIV among people who use drugs; the legislative provisions facilitating or requiring such practice should be repealed or significantly narrowed.

Compulsory drug dependence treatment

Under the *Law on narcological assistance*, the law states that a person may be involuntarily urgently hospitalized in a narcological centre in circumstances where she or he has grave psychological and somatic

1004 However, given other provisions in the same statute, described below, it does not appear that treatment is accessible on an anonymous basis; rather, it may be accessible on a confidential basis, with the law also providing various exceptions to that principle of confidentiality.

1005 *Law on narcological assistance*, Article 7.

1006 *Law on narcological assistance*, Article 25.

1007 *Law on narcological assistance*, Article 23

1008 *Ibid.*

1009 Ministry of Health of Tajikistan, "*On improving narcological assistance in the Republic of Tajikistan*", Order No. 485 (7 August 2006).

1010 *Law on narcological assistance*, Article 14.

1011 *Law on narcological assistance*, Article 22: "Narcological institutions of public health services and other departments with similar institutions, are obliged, together with the law enforcement bodies, to cooperate in providing narcological assistance to persons suffering from narcological diseases, and in preventing their actions posing a danger to their life and health and that of other people."

1012 *Law on narcological assistance*, Article 21.

disorder arising out of the use of psychoactive substances, such that she or he: (i) poses a direct danger to himself or herself or to other people; (ii) is unable to satisfy independently his or her own vital needs; or (iii) will, if untreated, suffer deterioration of mental condition causing serious harm to his or her health.[1013]

In addition, under the *Law on compulsory treatment of people with alcoholism and drug dependence*,[1014] all persons with drug dependence or alcoholism are declared to have a legal duty to seek and undergo treatment in institutions of the public health services. Those who evade treatment may be ordered by a court into specialized institutions for compulsory treatment. According to this statute, persons with drug dependence are supposed to be placed into special facilities for compulsory treatment which combine medical therapy and labour and are operated by the Ministry of Interior.[1015] However, according to the national expert group, these specialized facilities do not exist because of lack of funding and this law on compulsory treatment is not enforced (outside of prisons) because of lack of facilities to conduct compulsory treatment.

Enforcement of compulsory treatment is, however, the practice in the case of those convicted of a criminal offence. As noted above, upon being charged with a criminal offence, a person suspected of drug use will be required to undergo narcological examination. In the event that addiction is established, the court will order compulsory drug dependence treatment while in prison. The *Criminal Code* provides that compulsory treatment shall be imposed as part of the penal sentence, and that this shall be in addition to imprisonment, rather than as an alternative to imprisonment.[1016] It should be noted that, in this respect, Tajik law does not take full advantage of the flexibility offered by UN treaties on drug control, 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.[1017]

Opioid substitution treatment

Opioid substitution treatment (OST) is a well-studied, effective method of managing and treating opioid addiction used widely in many jurisdictions, and is recognized as a key element of HIV prevention among people who inject drugs.[1018] International drug control treaties ratified by Tajikistan do not prevent the use of medications such as methadone and buprenorphine as OST,[1019] and they are recognized by the World Health Organization as "essential medicines".[1020] Tajik law does not prevent the introduction of OST, but rather explicitly allows it.[1021]

However, the implementation of OST is lagging in Tajikistan. Against a backdrop of widespread addiction to opioids and a growing HIV epidemic linked to injection drug use, there is a need for quick action on this front, both to protect public health and to discharge Tajikistan's international human rights obligations, including the obligation to take positive measures to realize the highest attainable standard of health.[1022] Both the Ministry of Health's 2006 Order "*On improving narcological assistance*"[1023] and the "*Programme on counteracting the HIV/AIDS epidemic in the Republic of Tajikistan, 2007-2010*"[1024] mention substitution therapy. In 2008, welcome steps were taken toward introducing OST in two pilot programmes.[1025] It will be critical to ensure that such programmes are established and scaled-up successfully, and do not remain perpetually in the pilot phase, if their health benefits, including assisting with HIV prevention among people who inject drugs, are to be maximized.

1013 *Law on narcological assistance*, Article 9.

1014 *Law on compulsory treatment of people with alcoholism and drug dependence* (12 April 1991).

1015 *Ibid*.

1016 *Criminal Code*, Articles 96-101.

1017 *Single Convention on Narcotic Drugs*, 1961, UN, 520 UNTS 331, as amended by the 1972 Protocol, Article 36(2); *Convention on Psychotropic Substances*, 1971, UN, 1019 UNTS 175, Article 22; *Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances,* 1988, Article 3(4).

1018 WHO/UNODC/UNAIDS, *Position Paper: Substitution maintenance therapy in the management of opioid dependence and HIV/AIDS prevention*, 2004.

1019 UN International Drug Control Programme (UNDCP), *Flexibility of Treaty Provisions as Regards Harm Reduction Approaches*, Decision 74/10, E/INCB/2002/W.13/SS.5 (30 September 2002).

1020 WHO, *WHO Model List of Essential Medicines*, regularly updated, online: http://www.who.int/medicines/publications/essentialmedicines.

1021 Article 9 of the *Law on narcological assistance* mentions "alternative substitution therapy for those sick with narcotic addiction."

1022 *International Covenant on Economic, Social and Cultural Rights*, UN General Assembly, 993 UNTS 3 (1966), Articles 2 and 12.

1023 Ministry of Health, Order No.485.

1024 "*Program on Counteracting the HIV/AIDS Epidemic in the Republic of Tajikistan, 2007-2010*", Order No.86 (3 March 2007).

1025 Interview with Soulkhiddin Nidoev, Director of National Drug Monitoring and Prevention Centre of Tajikistan, Dushanbe, 11 October 2008.

Overdose prevention

Naloxone, an opioid antagonist medication used to counter the effects of opioid overdose (including suppression of the central nervous and respiratory systems), is listed by the WHO as an essential medication for treating poisonings.[1026] Naloxone has been registered in Tajikistan and is used by medical institutions to help in cases of overdose.[1027] However, it is included in the list of controlled substances, and is not legally handed out to people who use drugs, meaning that peer interventions (i.e., one drug user assisting another in the event of overdose) are not possible.

4B. HIV PREVENTION AND TREATMENT

Tajikistan's first *Law on prevention of the AIDS disease* was adopted in 1993. It was revised in 2005 and adopted as the new *Law on counteracting HIV/AIDS*, which was again amended at the end of 2008.[1028] The amended law contains a number of important provisions. In particular, the law:

- guarantees to "vulnerable groups" specific information and services aimed at changing risk behaviour;[1029]
- proclaims that HIV prevention is a government priority and that government action should be based on the principles of human rights;
- establishes the availability of anonymous and voluntary testing (although Tajik law also has numerous exceptions to this principle, noted below);[1030]
- includes HIV test results within the category of confidential information protected by law,[1031] and clarifies that state organizations are allowed to share health information without a person's consent only following a court order or the request of investigative law enforcement bodies;[1032]
- establishes that various kinds of qualified medical (including psychological) and social assistance is available free of charge to persons with HIV/AIDS;[1033]
- prohibits discrimination based on HIV-positive status in all areas, including access to treatment, in labour and in education, and prohibits the restriction of housing and other rights and legitimate interests of people with HIV and members of their families;[1034]
- establishes controls for the safety of medical preparations, biological fluids and tissues used for medical and scientific purposes;[1035]
- guarantees provision of HIV-related information and educational activities in penitentiaries;[1036]
- guarantees rights of prisoners and detainees to adequate health care services, counselling and referral to other health care services;
- stipulates the right of prisoners and detainees to confidential HIV testing and counseling with informed consent of the person;[1037] and
- prohibits discrimination of prisoners on the grounds of their HIV status.

One of the other welcome developments of the 2008 amendments to the HIV law is the abolition of deportation of foreigners testing HIV-positive (see below); however, the law still allows for the compulsory HIV testing of foreigners.

Addressing HIV among groups at high risk

The *Law on counteracting HIV/AIDS* specifically contemplates the need for efforts to address groups vul-

1026 WHO, WHO Model List of Essential Medicines, regularly updated, online: http://www.who.int/medicines/publications/essentialmedicines.

1027 Use of naloxone is governed by the Ministry of Health's order "On improving narcological assistance in the Republic of Tajikistan", Order No. 485 (7 August 2006).

1028 *Law on counteracting HIV/AIDS*, Law No. 150 (28 December 2005), as amended by the *Law on amendment of the Law of the Republic of Tajikistan 'On counteracting HIV/AIDS'*, Law No. 476 (31 December 2008).

1029 *Ibid*., Article 6.

1030 *Ibid*., Articles 7-8.

1031 *Ibid*., Article 11.

1032 *Ibid*., Article 12.

1033 *Ibid*., Article 14.

1034 *Ibid*., Articles 8, 11, 12 and 13.

1035 *Ibid*., Article 4.

1036 *Ibid*.

1037 *Ibid*., Article 14-1.

nerable to HIV, and the need for involvement of non-governmental organizations. In its section on "Intersectoral cooperation in counteracting HIV/AIDS", the law provides that official bodies of the public health services, together with the institutions addressing drug trafficking and public safety, *in cooperation with public organizations*, should develop and implement programmes for preventing HIV infection among injection drug users and other vulnerable groups.[1038] NGOs operate drop-in centres for people who use drugs in the cities of Dushanbe, Khojend and Khorog. With grants from the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM), 12 centres for sex workers, including some run by NGOs, were opened in the country, offering pre-test HIV counselling, condoms, HIV information and other and educational materials.

Compulsory or mandatory testing for HIV

HIV testing may be done in state public health services and private institutions that have received a proper license. According to the current law on HIV, donors of blood, organs, or tissues are subject to mandatory confidential HIV tests as a condition of donating. Some other categories of people, based on "epidemiological indications", are subject to compulsory HIV testing.[1039] However, the potentially negative impact of this provision is mitigated by the amendments of 2008 to the national law on HIV: as amended, the law now states that "epidemiological surveillance" is conducted with regard to the protection and priority of human rights and the confidentiality of test results.[1040]

In 2008, the Government of Tajikistan issued a resolution adopting a protocol on HIV testing, clarifying procedures of HIV testing and groups of people subject to mandatory and compulsory testing.[1041] The protocol lays down a detailed procedure for obtaining informed consent to HIV testing, the right to refuse testing at any stage, and the lists of people and professions required to undergo regular check-ups and obligatory testing. The protocol contains progressive elements such as providing for free, anonymous HIV testing and stating that pregnant women are tested voluntarily.[1042] Furthermore, all public and private bodies are prohibited from requiring a person to provide a medical certificate as to HIV status (except in circumstances stipulated in the protocol).[1043]

However, serious concerns remain with the scope of compulsory HIV testing under current Tajik law. Under the protocol adopted in 2008, persons with symptoms of HIV or AIDS, or symptoms of diseases associated with HIV/AIDS may be tested without consent.[1044] The appendix to the protocol specifies that this includes the following groups of patients:

- patients with clinical indications associated with HIV/AIDS (fever, diarrhea, loss of body mass, etc);
- patients with suspicion or diagnosis of certain diseases (e.g., Kaposi's sarcoma, tuberculosis, hepatitis B and C, etc.);
- patients who regularly receive blood transfusions;
- patients who have received donated blood or organs;
- children born to mothers living with HIV.[1045]

Additionally, involuntary HIV testing is conducted for certain people on the basis of "epidemiological indications", and as a pre-condition of employment and at regular check-ups.[1046] Appendix 3 to the protocol specifies groups of people who have to undergo HIV testing at employment and during regular check-ups:

1038 *Law on counteracting HIV/AIDS*, Article 23.

1039 *Ibid*., Article 9.

1040 *Ibid*, Article 4.

1041 Government of Tajikistan, "On Procedure of testing in order to identify persons infected with HIV, their registration, medical assistance to and surveillance of people living with HIV, and the list of people obliged to undergo mandatory confidential HIV testing on epidemiological indications" [Об утверждении Порядка медицинского освидетельствования с целью выявления заражения вирусом иммунодефицита человека, учета, медицинского обследования ВИЧ-инфицированных и профилактического наблюдения за ними и Списка лиц, подлежащих обязательному конфиденциальному медицинскому освидетельствованию на ВИЧ-инфекцию по эпидемиологическим показаниям], Resolution No. 171 (1 April 2008).

1042 *Ibid*., para. 7.

1043 *Ibid*., para 30.

1044 *Ibid*., para. 8.

1045 *Ibid*., Appendix 5, List of people to be mandatorily tested for HIV[Список лиц, подлежащих обязательному медицинскому обследованию на выявление заражения вирусом иммунодефицита человека].

1046 *Ibid*., para. 9.

- medical doctors, nurses who work at AIDS centres, other healthcare facilities who work with people living with HIV, and staff who carry out medical exam ordered by courts;
- health care staff of medical labs which carry out HIV testing;
- health care staff who deal with blood, such as surgeons, dentists, kidney specialists and those who assist with childbirth; and
- tattoo providers.[1047]

In addition, if employees of certain professions and positions are found to be HIV-positive, they must be transferred to a different occupation or work. If these workers refuse to undergo HIV testing, they are dismissed from work. Appendix 4 to the protocol specifies these professions:

- surgeons, those who assist with childbirth, specialists performing blood transfusions, and other specialists who work with blood; and
- health care staff working in infectious diseases settings where there is risk of developing HIV-associated illnesses (e.g., tuberculosis).[1048]

Following legislative amendments in 2008, any mandatory medical testing is carried out confidentially.[1049] People living with HIV and AIDS are subject to registration and surveillance (i.e., medical follow-up).[1050] Surveillance is carried out by AIDS centre and local health care facilities at least once every six months.[1051] As mentioned before, the law on HIV now states that "epidemiological surveillance" is carried out with regard to the protection and priority of human rights and the confidentiality of test results.[1052]

Foreign citizens entering Tajikistan for work, study, permanent residence or other purposes for more than three months are required to be tested for HIV within ten days from the date of arrival (unless arriving with a certificate of HIV-negative status). Until 2008 foreign citizens or stateless persons who tested HIV-positive were subject to deportation. In 2008, amendments to the national HIV law removed the deportation provision, although mandatory testing of foreigners remains in the law.[1053]

Compulsory treatment of HIV and other diseases and obligation to follow medical instructions

The *Law on public health care* establishes a general duty on everybody, without exception, to observe medical prescriptions issued by physicians.[1054] Furthermore, to prevent infectious diseases, people are obliged to receive immunization and medical examinations as determined by the bodies and institutions of the public health services. Failing or refusing to follow instructions or prescriptions of the attending physician constitutes evading treatment and can result in legal liability of the patient (or, in the case of minors, legal liability on the part of his or her parents or legal guardian).

The *Law on public health care* also addresses a number of specific health conditions of concern. People with tuberculosis, leprosy, AIDS, "venereal diseases" and other dangerous diseases (which are not further specified), are obliged to undergo examination and treatment upon request by medical institutions. Those who evade examination and treatment are subject to a compulsory enforcement of testing and treatment.[1055] In the case where a person evades "voluntary" treatment, the law provides for compulsory treatment.[1056] However, such provisions contradict other provisions of the *Law on public health care*: with the exception of pregnant women and minors, people have the right to refuse examination and treatment (in writing) at any stage for the diseases.[1057] (Persons who do not attend for examination or treatment, or

1047 *Ibid*., Appendix 3, List of professions and positions that have to undergo mandatory HIV testing [Перечень специальностей и должностей, подлежащих обязательному медицинскому освидетельствованию]

1048 *Ibid*. Appendix 4, List of specialists and professions which cannot be occupied by people living with HIV and AIDS [Перечень специальностей и должностей, на которых не допускается использование труда лиц, носителей ВИЧ и больных СПИДом].

1049 *Law on counteracting HIV/AIDS,* Article 7.

1050 Government of Tajikistan, Resolution No. 171, para 31.

1051 *Ibid*., para 35.

1052 *Law on counteracting HIV/AIDS*, Article 4.

1053 *Ibid*., Article 9.

1054 *Law on public health care*, Law. No. 419 (15 May 1997), Article 40.

1055 *Law on public health care*, Article 42.

1056 *Law on public health care*, Article 67.

1057 *Law on public health care*, Article 30. The denial of a woman's right to decline examination or treatment during pregnancy raises other serious human rights concerns (e.g., women's rights to privacy, to security of the person, and to equality); this warrants legislative amendment. While minors

those who transmit venereal diseases or HIV, may be held criminally liable.[1058])

Despite these restrictive provisions, there is a welcome difference between Tajik law and that of neighbouring countries in that, apart from the one provision of the *Law on public health care* noted just above, there is no separate definition and list of "socially dangerous diseases" in the legislation of Tajikistan. Lists of "socially dangerous diseases", which habitually include HIV and sometimes drug dependence, exist in several other countries in the region, and are used as a basis for (further) unjustifiable restrictions on the rights of people with the listed conditions.

Patients' rights, including confidentiality

The rights of medical patients in Tajikistan are stipulated by the *Law on public health care*, which states that a patient has the rights to a respectful and humane treatment from medical and other service personnel, to choose his or her doctor, and to the presence of a lawyer or other lawful representative for the protection of his or her rights.[1059] However, this list does not address such questions as the right to participate in choosing one's treatment or the protection of confidentiality of personal health information.

Separately, the *Law on counteracting HIV/AIDS* also establishes the rights of patients with HIV and AIDS. In addition to prohibiting medical institutions or emergency services from denying services to persons with HIV or AIDS, the law recognizes:

- the right to receive various kinds of medical aid (including specialized care) and medications;
- the right to confidentiality of health information, as long as a patient's condition and his or her life and work do not create a threat of infecting other persons with HIV;
- the right to compensation for damages suffered as a result of disclosure of information on HIV infection;
- the right to protection against discrimination, including in access to treatment; and
- the right to patients' active participation in determining goals of the treatment, including duration and methods, and termination of treatment.[1060]

Disclosure of "medical secrets" is a criminal offence in Tajikistan, punishable by a fine amounting to 200-500 times the official minimum wage and/or a prohibition on occupying certain posts or engaging in certain activities for up to two years.[1061] The same *Criminal Code* article provides for an even more severe penalty for breaching the confidentiality of a patient living with HIV, which may be punishable by imprisonment for up to two years, with a prohibition on occupying certain posts or engaging in certain activities for the same term. If violating patient confidentiality has led to grave consequences, the penalty may be increased to imprisonment for a term of two to five years, again accompanied by a prohibition on occupying certain posts or engaging in certain activities.[1062]

The *Law on counteracting HIV/AIDS* also explicitly establishes that a person's HIV status or AIDS diagnosis constitutes a professional secret, the confidentiality of which is protected by the law.[1063] Sharing of information about patients' health without their consent is allowed only following a court order or request by the investigatory bodies of the law enforcement. Each AIDS centre maintains a database of people with HIV with which it has contact. The composite database is stored in the national AIDS centre. Access to this main database is granted only to the head of the centre. No other organizations or individuals have lawful access to this database.

may lack legal and decision-making capacity that should be respected in adult women during pregnancy, many jurisdictions recognize that some "mature minors" are in a position to make their own decisions about medical procedures and their autonomy should be recognized; legislative reform to reflect this should be considered.

1058 Article 125 of the *Criminal Code* states that knowingly putting someone in danger of HIV infection is punished by a limitation of freedom for up to three years, or imprisonment for up to two years. Transmission of HIV by a person who knew of his/her HIV status is punished by imprisonment from two to five years. Article 126 of the *Criminal Code* provides for a fine or community labour for one to two years, or detention for up to six months for transmitting STIs.

1059 *Law on public health care*, Article 31.

1060 *Law on counteracting HIV/AIDS*, Article 12 (as amended in 2008).

1061 *Criminal Code*, Article 145.

1062 *Criminal Code*, Article 145(2), amended by Law No. 35 (17 May 2004).

1063 *Law on counteracting HIV/AIDS*, Article 11.

5. PRISONS

Tajikistan's correctional system

The correctional system falls under the purview of the Ministry of Justice. As of 2007, it consisted of 19 institutions: one prison, five investigative custody units, three "maximum security" colonies (for men), two "medium security" colonies (for men), one "minimum security" colony (for men), one institution for women (all levels of security), three settlement-type colonies (which are based on a less strict security level than other colonies), a hospital, and an institution for former law enforcement staff (all levels of security).

According to the national expert group, as of 2007, Tajikistan's correctional facilities contained a total of 2,328 persons serving punishments for drug or drug-related offences, representing roughly one-third of all those serving a term in correctional institutions. Depending on the gravity of an offence, offenders are generally sentenced to "maximum security" correctional facilities or "medium security" facilities; a minority is imprisoned in "minimum security" facilities or in special institutions for personnel of law enforcement bodies.[1064] In the case of less serious offences, a convicted person may be sentenced to a settlement-type colony or receive a conditional sentence that is served in the community rather than in a correctional institution.[1065] The national expert group notes that the correctional system does not maintain a tally of persons released on parole or receiving alternative punishments (i.e., not incarceration) for drug-related crimes.

The *Criminal Code* provides for exemption from punishment in some cases of disease.[1066] According to a joint order of the Ministries of Justice and Health, people with HIV infection in the stage of secondary diseases, with malignant neoplasms or disorders of the central nervous system, are exempted from further punishment.[1067] There are also cases when, after serving part of a sentence a person could be granted parole.[1068] [1069] Enforcement of a sentence may also be postponed if the person is undergoing psychiatric treatment.

HIV and risk behaviour in Tajikistan's prisons

As elsewhere, prisoners in Tajikistan are one of the groups most vulnerable to HIV infection. There is some data suggesting HIV risk behaviour likely occur in prisons in Tajikistan. For example, according to UNODC, more than one-third of prisoners had previously injected drugs.[1070] The following table shows, for recent years, the number of prisoners known to be living with HIV or tuberculosis in correctional institutions in Tajikistan:

Health condition/year	2003	2004	2005	2006	2007
Number of prisoners with HIV infection	52	92	115	128	129
Number of prisoners with tuberculosis	1800	1760	919	929	752

HIV prevention measures in prisons

The Ministry of Health's strategic plan on HIV/AIDS, adopted in 2004 and running until 2010, specifically recognizes the need for "prevention of HIV infection among prisoners."[1071] According to the Ministry's

1064 According to the national expert group of the Republic of Tajikistan, the breakdown of this total number of people in prison for drug-related offences in 2007 was as follows: 1528 persons in maximum security facilities, 778 persons in medium security facilities, 22 persons in minimum security facilities and 103 in special institutions for law enforcement personnel.

1065 *Code of Criminal Procedure of the Republic of Tajikistan* (August 17, 1961, last amended 20 March 2008).

1066 *Criminal Code*, Article 79.

1067 Ministry of Justice and Ministry of Health, "*On exemption from serving a punishment for convicts because of a disease*", Joint Order No.122/148 and No.578 of 20-21 November 2007.

1068 *Criminal Code*, Article 79.

1069 *Code of Criminal Procedure of the Republic of Tajikistan* (August 17, 1961, last amended 20 March 2008), Article 365.

1070 UNODC, *Central Asia: Kyrgyz Republic, Tajikistan and Uzbekistan: R*egional study on drug use and HIV/AIDS, Regional Summary, 2007, p. 52.

1071 "Strategic program of counteracting the HIV/AIDS epidemic in the system of the Ministry of Health of the Republic of Tajikistan, 2004-2010", 2004, Section 3.5. Similarly, as noted above, the national "Program on counteracting the HIV/AIDS epidemic in the Republic of Tajikistan, 2007-2010" also includes HIV prevention among prisoners.

strategic plan and to the information provided by the national expert group, comprehensive HIV and STI prevention programmes do not exist in all correctional institutions in the country. HIV prevention measures in pre-trial custody institutions and penitentiary institutions currently consist of educational seminars for prisoners and the distribution of condoms and information. The national expert group reports that materials for personal hygiene, including shaving accessories, are distributed (although in insufficient quantities), and disinfectant solutions and sterile medical equipment are available in the first-aid stations.

However, the national expert group's report also raises concerns. Prisoners' access to information materials and peer-to-peer education is limited. There are no programmes providing opioid substitution treatment in prisons, nor programmes to support drug users in achieving abstinence from drugs. There is poor integration of public health services into the prison system, and access to condoms, disinfecting substances, and treatment for prisoners with STIs or HIV infection is not satisfactory.

In the remaining period until 2010, the Ministry of Health plans significant improvements in HIV prevention programmes in all correctional facilities of the country. As the Ministry's strategic plan indicates, this requires greater coverage and supply of condoms and disinfectants, information, peer education programmes, better access to treatment of STIs, the introduction of substitution treatment in some institutions, and the piloting of needle and syringe programmes in some institutions.

Health care services in prisons

The medical department of the penitentiary system, under the Ministry of Justice, is responsible for health care services in institutions of the penitentiary system and in pre-trial detention facilities. Treatment and care of people living with HIV, hepatitis and tuberculosis is provided, including access to antiretroviral therapy (ART), as is voluntary HIV testing and counselling. However, according to the national expert group, medical facilities in pre-trial detention units and penitentiary institutions are not adequately supplied with medical accessories and medicines. According to the Penal *Code,*[1072] prisoners have the right to apply to the system of private medical services. Access to such services and needed medicines is a personal expense to be paid by the prisoner or his or her relatives.

As noted above, the *Criminal Code* provides for compulsory treatment of people with drug dependence in prisons, concurrently with the sentence of imprisonment.[1073] As in other countries of the region, no programmes for diversion of drug dependent offenders into treatment instead of imprisonment exist in Tajikistan (even though providing treatment as an alternative to imprisonment is allowed under the UN drug control treaties). According to the national expert group, treatment for drug dependence is limited in the prison system, consisting solely of detoxification. According to the *Penal Code*, housing and treatment of prisoners with chronic alcoholism and drug dependence is arranged in special medical penitentiary institutions.[1074]

Tajikistan is the only country participating in this project which has included mention of health care in relation to HIV in the penitentiary system in its HIV law.[1075] The law stipulates the right of prisoners and detainees with HIV to specific medical assistance, counselling and referral to other support services during imprisonment and detention. Prisoners have the right to confidential testing and counselling based on informed consent. Information about prisoners' or detainees' health is to be accessible only to health care staff, and may be disclosed only with the consent of the prisoner or if necessary to ensure the safety of other prisoners and prison staff. The law also prohibits discrimination of prisoners on the basis of their HIV status.[1076]

However, the national expert group has noted, with concern, that there are also limitations of the rights of prisoners with HIV or drug dependence.

- For example, according to the *Penal Code*, prisoners with HIV are to be segregated from the rest of the prison population,[1077] even though HIV is not casually communicable; while it appears that this provision is not generally enforced, it is legislative discrimination that should be repealed. (Prisoners with tuberculosis are segregated, according to the national expert group.)

- When prisoners are transported from one penitentiary facility to another, prisoners with tuberculosis, those who have not completed STI treatment, those with HIV and those with psychiatric disorders are transported separately from the rest.[1078]

- According to the *Penal Code*, after serving either half or one-third of a sentence (depending on the circumstances), a prisoner may be eligible for transfer to a lower-security institution for the remainder of his or her sentence.[1079] However, certain prisoners are not eligible for this transfer, including prisoners who have not completed their full term of compulsory treatment and prisoners who require special medical treatment in closed institutions.[1080]

- Similarly, prisoners who are deemed to demonstrate sufficiently good behaviour, and prisoners whose work is connected with movement outside of the institution, can be housed in special housing outside the penitentiary (within the borders agreed with the local district administration). This right is restricted for prisoners with HIV, and prisoners who have not completed treatment for alcoholism or drug dependence, STIs or tuberculosis.[1081]

In effect, these provisions regularly, and without justification, discriminate against entire categories of people based on their health status, rather than being based on case-by-case assessments of whether such restrictions are justified. They should be repealed.

1072 *Penal Code,* (6 August 2001, last amended 20 March 2008), Article 105(3).
1073 *Criminal Code of Tajikistan,* Articles 96-101.
1074 *Penal Code of Tajikistan* (6 August 2001), Article 105, and internal regulations of the penitentiary institutions.
1075 *Law on counteracting HIV/AIDS,* Article 14-1.
1076 *Ibid.*
1077 *Penal Code of Tajikistan*, Article 78.
1078 *Ibid.*, Article 74.
1079 *Ibid.*, Article 80.
1080 *Ibid.*, Article 80(3).
1081 *Ibid.*, Articles 99-100.

6. DISCRIMINATION AND RESTRICTION OF RIGHTS

There is a general rule prohibiting discrimination in the Constitution of the Republic of Tajikistan, which declares that the state guarantees equal rights without regard to nationality, race, sex, language, religion, political beliefs, education, social status or property status.[1082] Tajik law also prohibits discrimination, to at least some degree, on the basis of HIV status and on the basis of drug dependence.

The *Law on counteracting HIV/AIDS* prohibits "dismissal from work, refusal of employment, refusal of enrolment to educational institutions and institutions providing medical aid, and restriction of other rights and legitimate interests of HIV-positive person based on the fact of the infection, or equally, restriction of housing and other rights and legitimate interests of family members of the HIV-infected persons." The law prohibits discrimination on the ground of HIV status. Any public action with the purpose of inciting hatred and contempt to a person or a group of persons on the basis of actual or presumed HIV status is prohibited. Any limitation of rights and freedoms of people with HIV and AIDS must be justified by preservation of public health or rights and freedoms of others.[1083] This amendment introduced in 2008 makes Tajikistan the first country participating in the project to prohibit discrimination on the basis of both actual and presumed HIV-positive status.

The *Law on narcological assistance* declares that restricting the rights of persons with narcological diseases is not allowed, except for those restrictions provided by national legislation.[1084]

In reality however the situation is somewhat different. As noted by the national expert group, despite these prohibitions, discrimination based on HIV-positive status and on drug use is common. In addition, there exist some legislative and policy measures that arguably unjustifiably discriminate against people with HIV and vulnerable groups, including people who use drugs:

- For example, already outlined above are some policies and practices imposing compulsory drug testing and compulsory HIV testing that are not justifiable.

- HIV testing as a condition of employment is rarely justifiable, yet is currently found in Tajik legislation for some individuals. It is not factually sound to assume that a worker is incapable of performing the duties of certain occupations simply because he or she has HIV; therefore, blanket exclusions from holding certain positions are unjustifiable discrimination. Decisions about a person's competence to perform work should be made on an individual basis, not based on HIV status. International guidance in this area establishes that:

  > The right to work entails the right of every person to access to employment without any precondition except the necessary occupational qualifications. This right is violated when an applicant or employee is required to undergo mandatory testing for HIV and is refused employment or dismissed or refused access to employee benefits on the grounds of a positive result. States should ensure that persons living with HIV are allowed to work as long as they can carry out the functions of the job. Thereafter, as with any other illness, people living with HIV should be provided with reasonable accommodation to be able to continue working as long as possible and, when no longer able to work, be given equal access to existing sickness and disability schemes. The applicant or employee should not be required to disclose his or her HIV status to the employer nor in connection with his or her access to workers' compensation, pension benefits and health insurance schemes. States' obligations to prevent all forms of discrimination in the workplace, including on the grounds of HIV, should extend to the private sector.[1085]

- In addition, there is a list of certain kinds of trades and activities, considered to be higher-risk, from which someone may be barred based on drug use without a consideration of the individual case. For example, a diagnosis of drug or alcohol dependence can be a basis for automatically denying someone a driver's license. In addition, people with drug dependence are prohibited from certain kinds of employment that carries increased risk.

- HIV-positive status and drug dependence can also affect familial rights and responsibilities under Tajik law. According to a government resolution, HIV and drug dependence are included on a list of diseases that constitute grounds for denying someone's application to adopt a child.[1086] In addition, according to the *Family Code*, in cases of concern about child welfare, one or both parents of a child may be deprived of parental rights based on the following grounds: neglecting to perform parental duties; child abuse or mistreatment; committing a deliberate crime against the life or health of a child; or chronic alcoholism or drug dependence.[1087] The explicit reference to the health condition of alcoholism or drug dependence as a factor akin to mistreating a child mean that parents are vulnerable to losing their their children if such a diagnosis is *per se*, seen as adequate basis for such an order. The *Family Code* also releases a person from the legal duty to support his or her spouse if the spouse's disability results from abusing alcohol or narcotics.[1088] If one of the would-be spouses concealed from another an STI or "AIDS disease", another spouse has right to demand annulment of the marriage.[1089] One of the grounds impeding marriage is *limitation of legal capacity* by a court on the basis of one's misuse of alcohol or drugs.[1090]

According to principles well established in international human rights law, limitations or infringements on human rights may only be justified in accordance with clear standards.[1091] One key principle is that of non-discrimination, including based on health status. It will be the very rare case in which denying certain rights or benefits to entire classes of persons based on their health status (e.g., diagnosis with HIV infection or drug dependence) will be justifiable. Rather, discriminating in employment or denying parental rights should require case-by-case justifications, based on an assessment of individual circumstances, rather than based on inaccurate, generalized assumptions about a person's capacity to perform the functions of a job or to be a suitable parent based on health status.

1082 *Constitution of the Republic of Tajikistan,* Article 17.

1083 *Law on counteracting HIV/AIDS,* Article 13 (as amended in 2008).

1084 *Law on narcological assistance,* Article 8.

1085 UNAIDS/OHCHR, *International Guidelines on HIV/AIDS and Human Rights*, para. 149.

1086 Government of the Republic of Tajikistan, Resolution "On adopting a list of diseases in the presence of which one cannot adopt or receive custody of a child", Resolution No. 406 (1 October 2004). Drug dependence, HIV, TB and oncological diseases are on the list.

1087 *Family Code of the Republic of Tajikistan* (version of 29 April 2006 # 183, last amended 20 March 2008), Article 69.

1088 *Family Code of the Republic of Tajikistan*, Article 93.

1089 *Family Code of the Republic of Tajikistan*, Article 15(3).

1090 "Legal capacity" could be "limited" or "repealed" (cancelled) by court. Limitation of legal capacity is done following an application of relatives or government agencies is a person "puts him/her self or his/her family in difficult economic situation, because of abuse of alcohol or drugs". (*Civil Code of the Republic of Tajikistan*, last amended 1 March 2005, No. 85, Article 31).

1091 UN Economic and Social Council, *Siracusa Principles on the Limitation and Derogation Provisions in the International Covenant on Civil and Political Rights*, UN Doc. E/CN.4/1985/4, Annex (1985).

7. RECOMMENDATIONS

The recommendations below are aimed at addressing issues identified by the national expert group of Tajikistan and by the project's technical advisors. The national expert group also drafted a series of specific amendments to the *Law on counteracting HIV/AIDS* which it proposes; these are reproduced, as developed by the national expert group, in the Appendix below. Suggested language of legislative amendments is shown in shaded boxes.[1092]

National programmes and strategies

Recommendation 1: Ensuring attention to and involvement of vulnerable groups

In the interests of being more inclusive, and hence better informed and more effective, national programmes and strategies on HIV/AIDS and on drugs should explicitly guarantee:

- attention to HIV prevention, care, treatment and support for vulnerable groups, including people who use drugs and prisoners, among others; and
- the involvement of non-governmental organizations, people living with HIV, people who use drugs, and members of other vulnerable groups.

Administrative and criminal law issues

Recommendation 2: Repeal unnecessary, un-enforced prohibition on drug consumption

As noted above, the *Law on narcotics, psychotropic substances and precursors* (Article 15) currently states a prohibition on consumption of such substances without a prescription, but nothing in this or another law imposes a penalty. This provision serves no purpose but to stigmatize people with drug dependence; it is recommended that Article 15 be repealed.

Recommendation 3: Consider reducing penalties on possession of small quantities of drugs without intention to sell

As noted above, under the *Administrative Code* (Article 42), possession of drugs without an intention to sell attracts only administrative liability, punishable by a fine, in the case of very small quantities falling below the "small" [мелкие] quantities that can trigger criminal liability (e.g. less than 0.5g in the case of heroin). In this regard, Tajik law sets a positive example by eliminating criminal penalties in some circumstances of possessing minimal quantities of drugs without intention to sell. However, in many cases, Tajik law still imposes quite harsh penalties for possession of drugs even where there is *no intent to sell*. In the case of "small" minimal [мелкие] quantities (0,5-10g of heroin), while the penalty for a first offence may be limited to a fine, it could also carry a penalty of imprisonment for up to two years. In the case of a "minor" [небольшие] quantity (10-100g of heroin), the punishment for a first offence is from two to five years. The penalty for any subsequent offences, after a first offence, committed by group of people or in a prison, is a minimum penalty of five years, and up to a maximum of 8 years, and possibly confiscation of property as well — even if the possession still only involved "small" or "minor" quantities. Given the nature of drug dependence as a chronic, relapsing condition, criminalizing repeated possession of even small and minor quantities of a prohibited drug, even without intention to sell, criminalizes people with drug dependence. The Government of Tajikistan should consider entirely removing criminal penalties for possession of small quantities where there is no intention to sell. This could be achieved by enacting a provision such as the following in the *Criminal Code* (and in the *Administrative Code* as well should the decision be made to remove administrative penalties as well for possession of small quantities without intention to sell):[1093]

Decriminalization [or depenalization] of possession without intention to sell

The use and possession of a controlled substance in a small quantity with no intention to sell does not attract a criminal penalty [nor does it attract an administrative penalty].

Recommendation 4: Clear legislative framework for needle and syringe programmes

With the objective of supporting effective HIV prevention among injection drug users and protecting the public health more generally, the national expert group has recommended creating a clear legislative framework for needle and syringe programmes, including the disposal of used syringes. Wording of legislative provisions such as the following could be introduced to the existing *Law on counteracting HIV/AIDS* or other suitable legislation:[1094]

Sterile syringe programmes

1. "Sterile syringe programme" means a programme that provides access to sterile syringes and other related material, information on HIV transmission and other blood-borne pathogens, or referrals to substance abuse treatment services. It includes needle exchange programmes, needle distribution programmes and other forms of sterile syringe distribution.

2. Staff of the sterile syringe programme may provide a range of material and services, including the following:
   a) sterile syringes and other related material for safer injection drug use, including sterile water ampoules, swabs, filters, safe acid preparations, spoons and bowls and other appropriate materials;
   b) material to enable safer smoking and inhalation of drugs, such as pipes, stems, metal screens, alcohol wipes and lip balm;
   c) condoms and other safer sex materials, such as water-based lubricants and dental dams, as well as information about reducing the risks of HIV and other sexually transmitted infections; and
   d) first aid in emergency situations.

3. Staff of sterile syringe programmes may provide information including, but not limited to, the following:

   a) drug dependence treatment services and other health services;
   b) means of protection against transmissible diseases, including blood-borne diseases such as HIV;
   c) the risks associated with the use of controlled substances;
   d) harm reduction information specific to the drug being used, including safe injecting and inhaling practices;
   e) legal aid services;
   f) employment and vocational training services and centres; and
   g) available support services for people with drug dependence and their families.

4. The state shall ensure access to sterile syringes for people who require them. Where sterile syringes are not otherwise available and there is demand, the state shall establish a sterile syringe programme out of public funds. The state may distribute sterile syringes through public health facilities or provide funding to community organizations to operate sterile syringe programmes.

1092 In many instances, the wording of proposed legislative amendments is adapted from model provisions in Legislating for Health and Human Rights: Model Law on Drug Use and HIV/AIDS (Toronto: Canadian HIV/AIDS Legal Network, 2006), online in both English (www.aidslaw.ca/modellaw) and Russian (www.aidslaw.ca/modellaw-ru). This publication, consisting of a series of 8 modules on different issues, was used as a key reference by UNODC, national expert groups and the project's technical advisors during the review and assessment of national legislation in the countries participating in the project. Where relevant, citations below are to specific modules of that resource; the accompanying text and commentary to be found in those modules may be useful to legislators and policy-makers in implementing these recommendations.

1093 See *Legislating for Health and Human Rights: Model Law on Drug Use and HIV/AIDS*, Module 1: Criminal law issues, pp. 18-21.

1094 See *Legislating for Health and Human Rights*: *Model Law on Drug Use and HIV/AIDS*, Module 3: Sterile syringe programs, pp. 12-13.

Recommendation 5: Precluding criminal or administrative liability for harm reduction programmes

The harm reduction and outreach activities of non-governmental organizations targeting people who use drugs, such as programmes providing sterile syringes or other equipment to reduce harms associated with drug use (including HIV transmission), should be clearly exempt from possible liability. In particular, they should be exempt from liability under Article 203 ("involvement in drug use") or Article 205 ("organizing a site for drug consumption") of the *Criminal Code*, or under Article 42.1 of the *Code of Administrative responsibility* for "possession" of residual quantities of drugs in used injection or other equipment. Specific legislative provisions such as the following could achieve this: [1095]

Exemption from criminal liability for sterile syringe and other harm reduction programmes

Nothing in the *Criminal Code* or other law prevents the supply of sterile syringes and other related material, or the giving of advice, information or instruction on the safe use of syringes and other related material, by staff of a sterile syringe programme or other programme aimed at reducing harms associated with the use of prohibited narcotics or psychotropic substances. For greater clarity, any prohibition in the *Criminal Code* or other law on "involvement in drug use" does not apply to providing equipment and information on drug use for the purpose of preventing the spread of HIV and other blood-borne infections or other injuries or harms that may be associated with drug use.

No penalty for possession of residual amounts of substances in drug use equipment

A person who is in possession of any residual amount of a prohibited narcotic or psychotropic substance that is contained in or on a syringe or other equipment used to ingest such a substance does not, by the mere fact of that possession, commit an offence under any law.

Recommendation 6: Eliminate unjustifiably broad provisions for compulsory drug testing

Currently, Article 16 of the *Law on narcotics, psychotropic substances and precursors* authorizes compulsory drug testing on the basis of sufficient grounds to believe that a person has consumed illegal drugs, even though drug use is not a criminal or administrative offence in itself. In addition, Article 18 of the *Law on narcological assistance* currently states that: "Where there are grounds to believe that a person suffers from drug dependence, alcoholism, is under the influence of alcohol or narcotics, or has used a narcotic or psychotropic substance without a prescription from a medical doctor, the person may be referred for physical examination."[1096] As outlined above, such provisions infringe numerous human rights. Among other things, compulsory drug testing violates privacy and security of the person, without justification in most circumstances, since merely showing past use of drugs does not prove there is a risk of harm to self or others, which should be the only basis for possibly justifying an intrusion by the state into such rights. To eliminate unjustifiably broad provisions for compulsory drug testing, it is recommended that the Parliament of Tajikistan repeal Article 16 of the *Law on narcotics, psychotropic substances and precursors* and Article 18 of the *Law on narcological assistance*.[1097]

Recommendation 7: Decriminalise sex work

It is recommended to repeal Article 174.1 of the *Administrative Code of Tajikistan* (sex work). The *International Guidelines on HIV/AIDS and Human Rights* recommend that with regard to adult sex work that involves no victimization, criminal law should be reviewed with the aim of decriminalising and legally regulating occupational health and safety conditions to protect sex workers and their clients, including

1095 See *Legislating for Health and Human Rights: Model Law on Drug Use and HIV/AIDS*, Module 3: Sterile syringe programs, pp. 19-21.

1096 *Law on narcological assistance,* Article 18.

1097 It should be noted that involuntary intervention in cases where a person is at risk of being harmed, or harming others, as a result of drug dependence would still be possible under the terms of Article 9 of the Law on narcological assistance.

support for safe sex during sex work.[1098] Articles 238-239 of the Criminal Code are sufficient for punishing criminal behaviour in relation to sex work.

Recommendation 8: Eliminate HIV and STI-specific criminal law

Articles 125 and 126 of the *Criminal Code*, which specifically provide for punishment for transmission and exposure to "venereal diseases" and HIV, should be repealed. In the case of intentional transmission of venereal or HIV infection, this could be dealt with as infliction of bodily harm that is covered by other articles of the *Criminal Code*.

Drug dependence treatment

Recommendation 9: Implement opioid substitution treatment

Methods of drug dependence treatment need to be expanded and brought in line with international standards and good practice. It is recommended that the Ministry of Health introduce OST programmes immediately. As noted above, opioid substitution treatment is permitted under existing Tajik legislation, and is supported in both the national AIDS programme and a Ministry of Health order. Implementation of OST programmes should not be delayed; small-scale pilot projects approved in 2008 should proceed and be scaled-up. Additional legislation is not needed to move ahead with this important health service, which is critical to drug dependence treatment and to HIV prevention among people who inject drugs. Although not necessary, it may be useful to help support and sustain this programme to have a clear legislative basis, in which case an additional step could be to amend the *Law on narcological assistance* to add some provisions providing a clear framework for substitution therapy, one that protects and promotes the human rights of patients receiving OST.[1099]

Recommendation 10: Reform the system of registration of people who use drugs

In order to protect and respect human rights, and to remove reason for people to avoid seeking out treatment for drug dependence or help with problematic drug use, Tajikistan should abolish a central registry of people who use drugs and are dependent on it, which registry is then used in ways that can infringe human rights. To this end, the relevant paragraph of Article 14 of the *Law on narcological assistance* should be amended to repeal the provision on registration of people who use drugs; the relevant provisions of the Order of the Ministry of Health that implement such a registry should also be amended.[1100] (Obviously, centres providing drug dependence treatment need to maintain some individualized information about patients in order to deliver treatment properly, and can and should continue to do so, as health facilities do with other patients receiving other kinds of health services, with proper protections for the confidentiality of patients' health information.)

Recommendation 11: Provide for full confidentiality of health information of people who use drugs

As noted above, currently the *Law on narcological assistance* mandates that narcological institutions must "cooperate" with law enforcement bodies (Article 22) and also requires that they disclose, upon receipt of a written request, information about a person's drug dependence to various bodies, including the public prosecutor and judicial and investigative bodies (Article 21). Information exchange and cooperation between law enforcement bodies and the medical institutions engaged in treatment of drug dependence should be limited by law. Routine disclosure of such personal information, including health information, to law enforcement bodies undermines patients' trust in medical workers and drives them away from seeking medical services, including treatment for drug dependence. It is recommended that these

1098 *International Guidelines on HIV/AIDS and Human Rights* (Guideline 4, para. 21(c)).

1099 For model provisions that could be usefully incorporated into law to support OST programs that reflect human rights principles, see *Legislating for Health and Human Rights: Model Law on Drug Use and HIV/AIDS*, Module 2: Treatment for drug dependence, pp. 25-33.

1100 Ministry of Health of Tajikistan, "On *improvement of narcological assistance in the Republic of Tajikistan*", Order No. 485 (7 August 2006).

articles be amended to narrow significantly the scope of "cooperation" by narcological centres with law enforcement authorities and the requirement to disclose confidential health information.

Specifically, these articles in the *Law on narcological assistance* should be amended so as to permit (but not require) health professionals of such narcological centres to breach patient confidentiality only in circumstances where health professionals believe, in good faith and on reasonable grounds, that doing so is necessary to prevent imminent, serious harm to a patient or to another person. Additionally, health professionals should be required to share confidential information with law enforcement bodies only following court order. All other instances of sharing information should be prohibited.

In addition, the *Law on narcological assistance* should also be amended to include explicit provisions strengthening the confidentiality of health information of patients receiving narcological assistance. Provisions such as the following should be added to the legislation:[1101]

(1) The confidentiality of all health care information shall be respected. Records of the identity, diagnosis, prognosis or treatment of any patient which are created or obtained in the course of drug dependence treatment:
a) are confidential;
b) are not open to public inspection or disclosure;
c) shall not be shared with other individuals or agencies without the consent of the person to whom the record relates; and
d) shall not be discoverable or admissible during legal proceedings.

(2) No record referred to in Section (1) may be used to
a) initiate or substantiate any criminal charges against a patient; or
b) act as grounds for conducting any investigation of a patient.

(3) Programme staff cannot be compelled under any other law to provide evidence concerning the information that was entrusted to them or became known to them in this capacity.

(4) All use of personal information of patients and programme staff in research and evaluation shall be undertaken in conditions guaranteeing anonymity, and any such information shall also be governed by Section (2) of this article.

Recommendation 12: Reform legislation on compulsory drug dependence treatment

According to the national expert group, the *Law on compulsory treatment of people with alcoholism and drug dependence*, which is not implemented, should be repealed so as to abolish the possibility of compulsory treatment of drug dependence being applied to any person. As noted above, involuntary medical interventions are, absent some very clear and strong justification, a violation of basic human rights recognized in international law. At most, compulsory treatment for persons who are confirmed to be drug dependent (and not simply casual drug users) can only be justified as a last resort, in exceptional circumstances.[1102]

In addition, as noted above, the *Criminal Code* currently states that, in cases where a narcological exam establishes addiction, a person convicted of an offence will be subject to compulsory drug dependence treatment *in addition to* imprisonment. It is recommended that, in conformity with the international drug control treaties, the *Criminal Code* should be amended to allow such drug dependence treatment to be an *alternative* to imprisonment in at least some cases, rather than an additional sentence.

Recommendation 13: implement programmes on overdose prevention and managment

In order to prevent deaths and other serious harms from overdoses among opioid users, outreach workers (including those working for non-governmental organizations and including "peers" who are themselves persons who use or have previously used drugs), should be given the legal right to distribute and

1101 See *Legislating for Health and Human Rights: Model Law on Drug Use and HIV/AIDS*, Module 2: Treatment for drug dependence, pp. 20-22.

1102 Recall that the separate *Law on narcological assistance* already has some specific provisions about circumstances in which a person may be involuntarily hospitalized in a narcological centre out of concern for his or her health or that of others (Article 9).

administer medications such as naloxone in cases of overdose. This could be done by introducing provisions such as the following into the *Law on narcological assistance*:[1103]

Outreach to people who use drugs

(1) "Outreach work" means a community-oriented activity undertaken to contact and provide information and services to individuals or groups from particular populations at risk of blood-borne diseases, particularly those who are not effectively contacted or reached by existing information and services or through traditional health care channels.

(2) "Outreach workers" include paid social or public health workers or unpaid volunteers (including peers) of governmental or non-governmental facilities.

(3) Outreach workers may include people who currently use drugs, people who formerly used drugs or people who do not use drugs and are trusted by people who use drugs.

Administration of an opioid antagonist

(1) The Ministry of Health must make provision for the appropriate training of outreach workers in the administration of opioid antagonists.

(2) An outreach worker may administer an opioid antagonist to another person if:
a) the worker believes, in good faith, that the other person is experiencing a drug overdose; and
b) the worker acts with reasonable care in administering the drug to the other person.

(3) An outreach worker who administers an opioid antagonist to another person pursuant to Section (1) shall not be subject to civil liability or criminal prosecution as a result of the administration of the opioid antagonist.

In order to preclude overdose complications in prisons, it is recommended to allow peer educators among prisoners and prison staff to administer naloxone in case of overdose in penitentiary institutions, and train them to use this emergency response medication.

HIV prevention and treatment

Recommendation 14: Strengthening harm reduction measures

As noted above, in 2008 amendments to the *Law on counteracting HIV/AIDS* were enacted, which included an article proclaiming the government priority of HIV prevention, based on human rights principles and taking into account UN recommendations.[1104] This is a welcome development, but in order to further strengthen prevention, Tajik legislators might consider legislatively mandating measures to reduce harms, including HIV infection, among people who use drugs and prisoners. This should include directives specifically to government bodies and agencies that have particular responsibilities in this area, such as the Ministry of Health and Ministry of Justice, as well as clearly directing law enforcement bodies (e.g., the Drug Control Agency) to cooperate with other government bodies and with non-governmental organizations to ensure the effective delivery and operation of harm reduction services (e.g., sterile syringe programmes, OST).

Recommendation 15: Ensuring informed consent to HIV testing

The national expert group has reported that welcome steps are being taken to ensure a clear legal requirement to ensure people give consent to HIV testing that meets the requirements of informed consent, and that testing be accompanied by pre- and post-test counselling. While the details could be set out in

1103 See *Legislating for Health and Human Rights: Model Law on Drug Use and HIV/AIDS*, Module 6: Outreach and information, pp. 14-15.

1104 *Law on counteracting HIV/AIDS*, Article 6-1.

different instruments (e.g., a regulation or order from the Ministry of Health), it would also be advisable to include, in the *Law on counteracting HIV/AIDS*, a provision along the lines of the following:

> No test for HIV or other blood-borne infection shall be undertaken except with the informed voluntary consent of the person being tested, which informed consent should be clearly documented in writing.

Recommendation 16: Eliminating inconsistency and the infringement of human rights as relates to compulsory testing and treatment for HIV and STIs

The current *Law on counteracting HIV/AIDS* states the general principle that HIV testing should be voluntary and the *Law on public health care* also recognizes a general right to refuse medical examination and treatment. However, current Tajik law also contemplates numerous unwarranted exceptions to this principle, including other provisions in the *Law on public health care* that allow compulsory testing and treatment, as well as possible administrative or criminal liability for refusing or evading testing and treatment, in the case of various diseases, including HIV. This inconsistency, and the infringement of human rights reflected in compulsory medical interventions, should be addressed through legislative reforms to comply with international guidelines. Specifically:

- Articles 40, 42 and 67 of the *Law on public health care* should be amended to clarify that testing and treatment for HIV and other STIs cannot be imposed involuntarily simply by request of the public health services. Rather, if testing or treatment is ever to be imposed without consent, then it requires a process clearly set out in law, with a requirement that such measures be taken only in exceptional circumstances and with adequate justification that must be considered by an independent, judicial body, and with the most limited infringement of human rights possible.[1105]

- Article 40 of the *Law on public health* ("Responsibility of people to follow physician's orders") according to which not following a physician's orders is considered avoiding treatment and leads to legal liability, should be removed. In addition, the following provisions authorizing compulsory testing and treatment should be repealed: Article 42 of the *Law on public health* ("Responsibility of people with TB, leprosy, AIDS and venereal diseases") authorizing compulsory testing and treatment upon demand by public health authorities; Article 67 of the *Law on public health*, according to which people with AIDS and venereal diseases who avoid treatment are legally liable; and provision of the *Code of Administrative Responsibility*, providing for liability for avoiding treatment and testing.

Recommendation 17: Providing for protection of other patient rights

While the *Law on public health care* currently recognizes some important rights of patients, it should be strengthened — to the benefit of all patients, and not just those with HIV, STIs or drug dependence — by explicitly adding provisions such as the following to Article 31:[1106]

> Every patient has the right:
>
> a) to treatment and provided in accordance with good clinical practice;
> b) to treatment without discrimination;
> c) to meaningful participation in determining his or her own treatment goals;
> d) to meaningful participation in all treatment decisions, including when and how treatment is initiated and withdrawal from treatment;
> e) to exercise his or her rights as a patient;
> f) to confidentiality of medical records and clinical test results; and
> g) to be fully informed, including but not limited to the right to receive information about:
> i) his or her state of health;
> ii) his or her rights and obligations as a patient, as specified in any applicable law;
> iii) the procedure for making a complaint about health services received; and
> iv) cost and payment conditions and the availability of medical insurance and other possible subsidies.
> v) to decline treatment and testing

1105 Guidelines such as the UN's *Siracusa Principles* on permissible limitations on human rights should be complied with in any legislative provision that would allow involuntary testing or treatment. It is worth noting that the *Law on public health care* (Article 31) already recognizes that a patient should have the right to a lawyer or other representative to help ensure protection of his or her rights, so introducing amendments designed to strengthen the human rights not to be subjected to compulsory testing or treatment should build on that.

1106 See *Legislating for Health and Human Rights: Model Law on Drug Use and HIV/AIDS*, Module 2: Treatment for drug dependence, pp. 18-19.

Prisons

Recommendation 18: Provide access to voluntary drug dependence treatment, including OST in prisons

Given the high prevalence of drug dependence among those imprisoned, the significance of risky drug use practices in contributing to the HIV epidemic, and the importance of providing access to health services that respect human rights and help promote the highest attainable standard of health for all persons, it is recommended that Tajikistan implement voluntary drug dependence treatment programmes in prisons. As OST is made available outside prisons, it should similarly be made available inside prisons as one important element of programmes for addressing drug dependence.

To this end, if amendments are introduced to the *Law on narcological assistance* so as to create a clear legal framework for substitution therapy that protects and promotes the human rights of patients receiving OST (as suggested above in Recommendation 6), those amendments should include explicit reference to providing access to OST to drug-dependent persons in prisons. Such a provision could be worded as follows (and could also be inserted into legislation such as the *Penal Code*):[1107]

> **Opioid substitution treatment programmes in prison**
>
> (1) The Ministry of Health, with the support and cooperation of the Ministry of Justice, shall establish opioid substitution treatment programmes in all prisons.
>
> (2) Prisoners with opioid dependence shall be eligible for opioid substitution treatment in accordance with opioid substitution treatment guidelines applicable in the community.
>
> (3) Opioid substitution treatment shall be available for free on imprisonment and throughout the duration of imprisonment.
>
> (4) Opioid substitution treatment shall not be restricted to those on a course of opioid substitution treatment prior to imprisonment; all prisoners shall be entitled, if eligible, to being on opioid substitution treatment while incarcerated.
>
> (5) Participation in the opioid substitution treatment programmes shall be offered on a voluntary basis to all prisoners with opioid dependence.
>
> (6) Opioid substitution treatment programmes may include a variety of approaches, including maintenance treatment.
>
> (7) The programme shall ensure that staff members, prison officers, policy makers and prisoners have factual information regarding opioid substitution treatment.
>
> (8) The programme shall develop a comprehensive discharge planning system for prisoners nearing release, including a system for referral to opioid substitution treatment programmes in the general community.

1107 See *Legislating for Health and Human Rights: Model Law on Drug Use and HIV/AIDS*, Module 5: Prisons, pp. 30-32.

Recommendation 19: HIV prevention in prisons and detention facilities

In order to strengthen HIV prevention efforts in prisons and pre-trial detention facilities, legislative amendments could mandate the introduction of harm reduction programmes in prisons. Internal regulations of penitentiary institutions should be revised to strengthen HIV prevention among prisoners, including by ordering measures to ensure access to bleach and sterile syringes, as well as ensuring access to condoms, and information related to risks of HIV transmission through unsafe sex or drug use. The Internal Regulations' provisions prohibiting prisoners from possessing needles and syringes should be removed, as these represent a barrier to implementing needle and syringe programmes in prisons. Provisions such as the following could be inserted into the *Law on counteracting HIV/AIDS* and/or the *Penal Code*:[1108]

Distribution and possession of condoms and other safer sex materials in prisons

(1) The Ministry of Health and the Ministry of Justice shall ensure that condoms and other safer sex materials, along with appropriate information on their proper use and on their importance in preventing the spread of HIV infection and other sexually transmitted infections, are made available and easily accessible to prisoners in a manner that protects their anonymity.

(2) The Ministry of Health shall develop a plan for the disposal of used condoms that protects the anonymity of prisoners and the health of prison officers.

(3) The distribution and possession of condoms and other safer sex materials in prisons in accordance with this law shall not constitute a criminal nor administrative offence, nor are condoms and other safer sex materials admissible as evidence of sexual relations for the purposes of determining any criminal or administrative offence.

Authorization of harm reduction programmes

(1) Harm reduction programmes shall be implemented in all prisons according to the provisions set out herein, with the objective of reducing harms associated with unsafe use of drugs, including the risk of transmission of HIV or other blood-borne diseases.

(2) In order to prevent the spread of blood-borne diseases and minimize the health risks associated with drug use by prisoners, either the Ministry of Health or a local prison authority may authorize a specified person or organization (including non-governmental organisations) to deliver harm reduction programmes, including measures to supply sterile syringes and other related material to prisoners, as well as condoms and other materials to reduce the risks of HIV and other sexually transmitted infections.

Information

Staff of harm reduction programmes may also provide information including, but not limited to, the following:

(a) drug dependence treatment services and other health services;
(b) means of protection against transmissible diseases, including blood-borne diseases such as HIV;
(c) the risks associated with the use of controlled substances;
(d) harm reduction information specific to the drug being used, including safe injecting and inhaling practices;
(e) legal aid services;
(f) employment and vocational training services and centres; and
(g) available support services for people with drug dependence and their families.

Distribution and possession of sterile syringes and related material

(1) An authorized person or organization may distribute sterile syringes and related material via one or more of the following means:
(a) prison nurses or physicians based in a medical unit or other area(s) of the prison;
(b) prisoners trained as peer outreach workers;
(c) non-governmental organizations or health professionals who enter the prison for this purpose;
(d) one-for-one automated sterile syringe-dispensing machines.

(2) Wherever possible, sterile syringes and related material shall be made available to prisoners without the necessity of the prisoner identifying himself or herself to prison authorities.

(3) The Ministry of Justice, in consultation with the Ministry of Health shall establish rules for the safe storage of syringes possessed by prisoners in accordance with this law.

(4) The sterile syringe programme shall include measures to encourage safe disposal of syringes and monitor the number of syringes distributed and the number in storage.

(5) Sterile syringes and related material distributed by harm reduction programmes shall be used only in accordance with this law and any other applicable Regulations or institutional policies established by the relevant authority.

(6) The distribution and possession of syringes and related material in prison in accordance with this law shall not constitute a criminal nor administrative offence, nor shall such items be admissible as evidence of illegal drug use for the purposes of determining any criminal or administrative offence.

Availability of bleach as a disinfectant

(1) Bleach and instructions on using bleach as a disinfectant shall be made available in accordance with this law and any other applicable Regulations or institutional policies established pursuant to this law.

(2) Any such Regulations or policies established pursuant to Section (1) will:
(a) encourage participation of prisoners and their assistance in bleach distribution;
(b) ensure that bleach is available to prisoners in ways that preserve prisoners' anonymity; and
(c) ensure that in no instance shall a prisoner be required to approach a staff member in order to obtain bleach.

(3) Bleach distributed pursuant to this law shall be used only in accordance with this law and any other applicable Regulations or institutional policies established pursuant to this law.

(4) The distribution and possession of bleach in prison in accordance with this law shall not constitute a criminal nor administrative offence, nor shall such items be admissible as evidence of illegal drug use for the purposes of determining any criminal or administrative offence.

Information and education programmes regarding HIV/AIDS, other blood-borne diseases and drug dependence treatment in prisons

(1) The Ministry of Health shall develop and implement information and education programmes in every prison to help prevent the spread of HIV, other blood-borne diseases, and to address drug dependence among prisoners.

(2) In developing such programmes, the Ministry of Health shall use materials that are likely to be effective in reducing transmission of blood-borne diseases within prisons and outside prison following the release of prisoners, as well as providing information on treatment, care and support.

(3) Such programmes required by Section (1) may include peer education and use of non-Ministry of Justice personnel, including delivery of these programmes by community-based organizations.

(4) Materials shall, as much as possible, be available in the languages of the relevant populations,

1108 See *Legislating for Health and Human Rights: Model Law on Drug Use and HIV/AIDS*, Module 5: Prisons, pp. 25-30.

shall take into account the literacy level of the relevant populations, and shall be sensitive to the social and cultural needs of the relevant populations.

Responsibility of the Ministry of Health for providing training and education

The Ministry of Health is responsible for ensuring:

(a) that training and education are provided to staff and prisoners on a regular basis, and that such training and education include the principles of standard precautions to prevent and control blood borne diseases; the personal responsibility of staff and prisoners to protect themselves and others at all times; and information on post-exposure prophylaxis, if available;

(b) that training and education provided to prisoners also include available services and treatments; and peer education and counselling programmes that include the meaningful participation of prisoners as counsellors; and

(c) that prisoners and staff who may be exposed to blood and body fluids receive training in universal precautions.

Recommendation 20: Eliminating discrimination against prisoners with HIV or drug dependence

To eliminate discrimination currently embedded in the law, the *Penal Code* should be amended in a number of ways, as follows:

- Repeal the prohibition on transferring prisoners who are ordered to undergo compulsory drug dependence treatment to better conditions (lower security institutions).
- Remove HIV-positive status and the fact of not completing a full course of treatment for drug dependence or STIs from Articles 80 and 100 (and others as follows) as factors that restrict a prisoner's right to transfer and movement.
- Although it is reportedly not enforced at the moment, Article 78, which provides for the segregation of HIV-positive prisoners, is discriminatory and should be abolished.

Discrimination

As noted above, current Tajik law includes very important provisions prohibiting, in general terms, discrimination against people based on actual or perceived HIV-positive status[1109] and drug dependence.[1110] Yet at the same time, discrimination is a reality and Tajik law itself contains discriminatory provisions in other areas. Legal protections against discrimination are important elements of successfully addressing the marginalization that contributes, in multiple ways, to people's vulnerability to HIV and to experiencing even more severely the impact of HIV infection. Tajik law can be strengthened in several ways in this regard in order to comply with human rights principles.

Recommendation 21: Eliminating HIV testing in employment or educational settings

Current Tajik law already prohibits refusing to employ someone or dismissing someone from employment based on HIV status. However, it would be useful to recognize explicitly that requiring HIV testing before or during employment or attendance at an educational institution amounts to unjustified discrimination.[1111] A legislative amendment to the *Law on counteracting HIV/AIDS* should prohibit such practices. A

1109 *Law on counteracting HIV/AIDS*, Article 13.

1110 *Law on narcological assistance*, Article 8.

1111 E.g., see UNAIDS/OHCHR, *International Guidelines on HIV/AIDS and Human Rights*, para. 149. Similar analysis would apply to discrimination against someone based on something like infection with hepatitis B or C virus (HBV, HCV) or on the basis of a sexually transmitted infection. Given modes of transmission, many people who inject drugs are vulnerable to infection with other blood-borne diseases such as HBV or HCV, in addition to HIV, and may face discrimination on that basis, as has been observed in other jurisdictions. In making amendments to strengthen protection against HIV-related discrimination in an area such as employment or educational contexts, it would be advisable to explicitly include protection against discrimination based on such other diseases.

provision could be worded as follows:

> Discriminating against a person on the basis of his or her HIV infection or AIDS diagnosis is prohibited, including but not limited to such contexts as employment or education. It is unlawful discrimination to require that a person be tested for HIV as a condition of employment or enrolment in an educational institution, either before or during employment or enrolment.

Recommendation 22: Eliminating discrimination against drug-dependent persons in employment or educational settings

Requiring drug testing *before* employment or enrolment in an educational institution is also unjustified discrimination based on health condition. Requiring testing for drug use *during* employment may only be potentially justifiable in quite limited circumstances, such as limiting testing to positions that are safety-sensitive and then only in cases where there are reasonable grounds to suspect impairment or possibly random drug testing of persons returning to work after receiving drug dependence treatment. It is recommended that the law (perhaps the *Law on narcological assistance*) be amended to include a provision along the lines of the following:[1112]

> **Discrimination based on drug use**
>
> (1) Absent a reasonable justification given the circumstances of the case, it is prohibited to discriminate against a person, or a relative or associate of the person, on the ground that the person uses or has used drugs, or is perceived to use or have used drugs.
>
> (2) It is unlawful discrimination to require that a person undergo drug testing as condition of enrolment in an educational institution, either before or during enrolment.
>
> (3) It is unlawful discrimination to require that a person undergo drug testing as a pre-condition of employment. Making drug testing a condition of continued employment is permitted only in positions, as designated by [suitable government authority], where impairment while at work may pose a significant risk of harm to the individual employee or to others *and* where there are reasonable grounds to suspect that the individual employee may be impaired by drug use.

Recommendation 23: Respecting and protecting family relationships

The *Law on counteracting HIV/AIDS* prohibits restricting the "rights and legitimate interests" of people with HIV based on HIV-positive status and "equally, restriction of housing and other rights and legitimate interests of family members of the HIV-infected persons".[1113] Yet, as noted above, current law states that mere HIV-positive status[1114] can be a basis for denying someone's application to adopt; this blanket discrimination simply on the basis of a health condition, without regard for individual circumstances, is not justified. Similarly, it is of concern that, in cases of concern about child abuse or neglect, drug dependence could be assumed to be *per se* a sufficient basis to deprive someone of parental rights. In light of this:

- Articles 69 and 14(5) of the *Family Code* should be amended to clarify that, in cases of concern about child abuse or neglect, drug dependence should not be assumed to be *per se* sufficient grounds to deprive someone of parental rights, but rather than a careful analysis of the individual circumstances is required. In addition, the limitation of the right to marry based on drug dependence should be removed.
- The government resolution that lists HIV and drug dependence as barriers to adopting or receiving custody of a child should be amended to delete these conditions from the list.

1112 See *Legislating for Health and Human Rights: Model Law on Drug Use and HIV/AIDS*, Module 7: Stigma and discrimination, pp. 13-15.

1113 *Law on counteracting HIV/AIDS,* Article 13.

1114 *Family Code of the Republic of Tajikistan*, (13 November 1998, last amended 20 March 2008), Article 69; Government of the Republic of Tajikistan, Resolution "On adopting a list of diseases in the presence of which one cannot adopt or receive custody of a child", Resolution No. 406 (1 October 2004)..

TURKMENISTAN

SUMMARY REPORT AND RECOMMENDATIONS

TURKMENISTAN: SUMMARY REPORT AND RECOMMENDATIONS

1. BACKGROUND

Turkmenistan, with a population of more than 6 million, is a country with a very low prevalence of HIV according to official statistics: as of December 2007, official reports indicated only two cases of HIV infection to date.[1115] However, the number of people who use drugs is considerably higher: on the basis of the data from the narcological service, as of December 2007, there were 33,000 registered drug users.[1116] According to the UNODC, the rate of newly registered drug users was 32.5 per 100,000 people.[1117] The need for HIV prevention efforts, among both vulnerable groups and the population as a whole, has been recognized.

1115 UNAIDS, *2008 Report on the global AIDS epidemic* (Geneva, 2008), Annex 1. This information is supported by the information presented by the experts.

1116 United Nations Office on Drugs and Crime, Regional Office for Central Asia, *Compendium of Drug Related statistics*, 1997-2008, June 2008. p. 29.

1117 Ibid.

2. NATIONAL PROGRAMMES AND STRATEGIES

Programme on HIV/AIDS

In 2005, the Cabinet of Ministers approved the "National Programme on the Prevention of HIV/AIDS and STIs in Turkmenistan for 2005-2010".[1118] The programme was developed by the Inter-agency Coordinating Committee on the Prevention of HIV/AIDS/STDs (ICC). Responsibility for its implementation was assigned to the Ministry of Health and Medical Industry. There is also a "National Programme on the Prevention and Treatment of Tuberculosis for 2005-2009".[1119]

Stated key activities of the national HIV/AIDS and STI programme include:

- educating the public, youth, military personnel, health care workers, prisoners, people who use drugs, students, sex workers about HIV and STI prevention measures;
- treatment and rehabilitation of persons with narcotics addiction;
- provision of medical aid to people with HIV and their families;
- implementing HIV and STI prevention efforts among *prisoners*, including providing information and other educational actions, and distribution of condoms;
- improving professional skills of experts in the fields of prevention and HIV/AIDS treatment;
- training doctors and experts to provide HIV testing and pre-and post-test counseling at anonymous testing sites, HIV prevention centres and STI clinics;
- training people who use injection drugs as volunteers to deliver "peer-to-peer" HIV and STI prevention education and services; and
- preventive interventions for sex workers.

The programme does not contain any anti-discrimination provisions or provisions to protect the confidentiality of people living with HIV and STI. Instead, the programme provides for HIV and STI testing of those with drug dependence, and obligatory HIV and STI testing of pregnant women, provisions which raise human rights and public health concerns (addressed in more detail below).[1120] There is no specific legislative provision on the involvement of NGOs, persons living with HIV or persons who use drugs in work of bodies on HIV/AIDS. However, the national expert group states that there are no restrictions on activities of NGOs in the field of HIV prevention and consumption of drugs, including in institutions of the penitentiary system.[1121]

The national expert group has recommended that, in order to improve the effectiveness of the National Programme, there should be: closer cooperation with civil society organizations; better coordination of the activities of state and non-state stakeholders; better financing for the programme's activities; and more highly qualified experts.

Programme on narcotic drugs

In 2006, the Government of Turkmenistan adopted a "*National Programme on Counteracting Drug Trafficking and Assistance to Persons with Addiction to Narcotics and Psychotropic Drugs for 2006-2010*".[1122] The programme was developed by the State Steering Committee to combat drug dependence (under the Cabinet of Ministers), which Committee includes representatives of law enforcement bodies and the system of public health services. The Committee coordinates all actions directed at countering drug trafficking, as well as prevention and treatment of narcotic addiction, and has supervisory functions over ministries and agencies responsible for implementing concrete measures in these areas. The Committee also initiates and facilitates epidemiological and statistical studies related to the drug situation in Turkmenistan.

The National Programme against drugs is funded from the state budget. International organisations, following agreements with Turkmen government provide financial and technical support in implementation of national plans and programmes.

The programme includes:

- activities aimed at legislation development;
- activities to counter illegal drug trafficking;
- activities to control legal circulation of narcotics, psychotropic substances and precursors;
- activities to provide medical and social care for persons dependent to narcotics and psychotropic substances; and
- international cooperation.

The programme does not include reference to any harm reduction measures, such as programmes of opioid substitution therapy (OST) or needle and syringe programmes (NSP). Rather, its components are focused only on reducing drug supply (through law enforcement measures) and reducing drug demand. With respect to demand reduction, the programme includes drug use prevention measures such as educational activities for the population as a whole, as well as activities targeting youth. The programme includes a plan to establish a hospital for the compulsory treatment of women with drug dependence. In addition, the National Programme provides for compulsory drug testing of workers in the workplace as an ostensible prevention measure.[1123]

Along with these measures, the government plans to conduct annual epidemiological surveys of HIV prevalence among people who inject drugs, and to open new medical and rehabilitation centres and telephone hotlines in the remote districts and in cities where narcotic use is deemed to be extensive enough to warrant such services. Representatives of civil society were not involved in the development of the National Programme, but quasi-governmental public organizations are involved in a number of the programme's activities.

1118 The program was approved by an order of the Vice-Chairman of the Cabinet of Ministers of Turkmenistan, Order No. БГ/05 (27 April 2005).

1119 The program on prevention and treatment of tuberculosis was approved by the order of the Vice-Chairman of the Cabinet of Ministers of Turkmenistan, Order No. БГ/02 (13 April 2005).

1120 The national expert team has noted that international guidance, including from United Nations agencies working in the field of HIV and AIDS, recommends generally that HIV testing should be voluntary, done only with informed and free consent, with appropriate pre- and post-test counselling and with protection for the confidentiality of test results: UNAIDS/WHO Policy Statement on HIV Testing (June 2004).

1121 NGOs may carry out activities on the basis of the *Law on public organizations* [Закон Туркменистана об общественных объединениях], 21 October 2003.

1122 The program is approved by the Decision of the President of Turkmenistan "On the creation of the National Program on Counteracting Drug Trafficking and Assistance to Persons with Addiction to Narcotics and Psychotropic Substances for 2006-2010," Decision No. 7856 (24 April 2006). [Национальная программа по противодействию незаконному обороту наркотиков и оказанию помощи лицам, находящимся в зависимости от наркотических средств и психотропных веществ].

1123 Para. 34 of the National Program on Counteraction to Drug Trafficking for 2006-2010 calls for drug testing of workers in the workplace.

3. CRIMINAL AND ADMINISTRATIVE LAW PROVISIONS

Law on narcotics
According to the *Law on narcotic drugs, psychotropic substances, precursors and measures to counter their illegal circulation* (hereinafter "*Law on narcotics*"), the substances which are subject to control in Turkmenistan are those on a list approved by the President.[1124] The following categories have been established through such lists, with varying control measures applied by the state:

- narcotics and psychotropic substances whose distribution is forbidden;
- substances used as medical preparations for which distribution is limited, subject to specific control measures;
- substances used as medical preparations for which distribution is limited, subject to lesser means of control;
- multi-component medical products that contain narcotics, psychotropic substances or precursors, but which are not subject to control;
- precursors whose distribution is limited, subject to specific control measures; and
- narcotics and psychotropic substances which have been found in illegal circulation in small, large and extra large quantities. (Schedules set out what constitute "small", "large" and "extra large" quantities of various prohibited drugs.)[1125]

The *Law on narcotics* forbids consumption of narcotics and psychotropic substances without a physician's prescription,[1126] but there is no administrative or criminal liability or punishment under Turkmen law for the *use* of narcotics *per se*. However, there is administrative liability for possession of very small quantities of drugs not for sale. Similarly, the *Law on narcotics* does not create liability simply for possessing drug use equipment (e.g., syringes, disinfectants, utensils, etc.), but it does provides for confiscation of tools and equipment used for illegal manufacturing and consumption of narcotics.[1127]

However, the *Law on narcotics* (on detecting persons illegally consuming narcotics and psychotropic substances) states that if there is information that a person uses drugs illegally, or if there is a "founded suspicion" [обоснованное подозрение] that a person is under the influence of drugs, he/she should be tested.[1128] Illegal drug use may also be confirmed by statements from witnesses. Such provisions contribute to an environment in which people who use drugs go (further) underground and create barriers to their access to health services, including drug dependence treatment, and other support services for social re-integration.

The *Law on narcotics* also forbids "propagation of narcotics". This includes a prohibition on any activity directed at public dissemination of ideas regarding the development, processing, application or use of narcotics (including producing or distributing books or mass media containing such ideas), as well as a prohibition on "promoting the use in medical practice of medical products containing narcotics" that aims to suppress a patient's or negatively affect mental and physical health.[1129] Nothing in the law of Turkmenistan clearly exempts harm reduction measures from the possible scope of this prohibition, leaving it open to possible misinterpretation that could interfere with informing the population about opioid substitution treatment (OST) programmes or discussing the benefits of OST or other programmes that help prevent HIV infection or other harms associated with unsafe drug use. The national expert team has recommended that the government make it clear that such programmes do not contravene this law on "propagation"; this could be done by way of legislative amendment or other perhaps through other means (e.g., in an official policy document, decree or order accompanying the implementation of such programmes). This would facilitate the functioning of such programmes, including by reducing the risk of those working in such programmes being accused of breaching the law.

1124 The current list was adopted by Presidential Decree "On approved of lists of drugs, psychotropic substances and precursors", No. 9192 (13 November 2007).

1125 *Law on narcotic drugs, psychotropic substances, precursors and measures to counter their illegal circulation*, 9 October 2004, Article 2. [О наркотических средствах, психотропных веществах, прекурсорах и мерах противодействия их незаконному обороту] (Law on narcotics). See appendix for table with amounts in different categories under Turkmen law.

1126 *Law on narcotics*, Article 49.

1127 *Law on narcotics*, Article 45.

1128 *Law on narcotics*, Article 50.

1129 *Law on narcotics*, Article 47.

Administrative offences
Under the *Code of Turkmenistan on Administrative Offences* ("*Administrative Offences Code*"),[1130] the following offences connected with narcotics attract administrative liability:

- *Illegal acquisition or possession of narcotics in small quantities without an intention to sell* is an administrative offence. The penalty is a fine or administrative arrest for up to fifteen days. Someone who has voluntarily handed over the small quantities of narcotic which were acquired or possessed, without an intention to sell, is released from administrative liability.[1131]

- The *failure to undertake measures to secure cannabis and opium poppy crops*, and the places where such crops are stored or processed, against theft is an administrative offence, as is the failure to take measures to destroy remains of such crops after cultivation and the production wastes containing narcotic substances. The penalty is a fine to be imposed on officials.[1132]

- *Illegal cultivation of opium poppy or cannabis* can lead to a warning or fine (other than in the case of types of poppy and cannabis whose cultivation is prohibited and which cultivation attracts more severe penalties under the *Criminal Code* – see below).[1133]

Criminal offences
Under Turkmenistan's *Criminal Code*,[1134] the following offences connected with narcotics attract criminal liability:

- Illegally acquiring or possessing narcotics or psychotropic substances *in a small quantity, without an intention to sell, when committed for the second time within a year* after administrative charges were imposed for the same conduct, is punishable with a fine, corrective works for up to two years or imprisonment for up to two years.[1135]

- Illegally manufacturing, processing, acquiring, possessing, transporting or transferring a narcotic or psychotropic substance, *without an intention to sell*, is punishable by imprisonment for a term of up to five years.[1136] The same offence committed for the second time or by an organized group leads to imprisonment from three to 10 years.

- Illegally manufacturing, processing, acquiring, possessing, transporting, or transferring narcotics or psychotropic substances, *with an intention to sell*, is punishable by imprisonment for three to ten years, with or without confiscation of property.[1137]

- Illegally cultivating prohibited plants containing narcotic substances is punishable by corrective works for up to two years or imprisonment for up to three years.[1138]

- "Inducing consumption" of narcotics or psychotropic substances is punishable with imprisonment for up to five years and/or compulsory residence in a certain district for a term of two to five years. Inducement is understood as any deliberate actions directed at other persons to create a desire to consume (e.g., persuading, offering, advising, etc.).[1139]

1130 *Code of Turkmenistan on Administrative offences* [Кодекс Туркменистана об административных правонарушениях], Law No. 35 (17 December 1984, last amended in 2002). According to the Code (Article 14), administrative liability can be imposed as of 16 years of age.

1131 *Administrative Offences Code*, Article 43(1).

1132 *Administrative Offences Code*, Article 102-1.

1133 *Administrative Offences Code*, Article 102-2.

1134 *Criminal Code of Turkmenistan*, Law No. 222-1 (12 June 1997).

1135 *Criminal Code*, Article 298.

1136 *Criminal Code*, Article 293.

1137 *Criminal Code*, Article 292.

1138 *Criminal Code*, Article 295.

1139 *Criminal* Code, Article 296. There is nothing that clearly acknowledges that measures aimed at reducing harms associated with drug use are exempt from this provision.

- *Organizing the consumption* of narcotics or psychotropic substances in family celebrations, festivals, demonstrations or other mass actions is punishable by a fine or imprisonment for up to five years.[1140]

- *Organizing or maintaining sites for the consumption* of narcotics or psychotropic substances is punishable with imprisonment for a term of three to eight years, and may also include compulsory residence in a certain district for a term of two to five years.[1141] Granting the use of premises for the consumption of narcotics or psychotropic substances is punishable by imprisonment for up to three years and/or obligatory residence in certain district for a term of two to five years.[1142]

Usually, criminal liability only arises for those aged 16 or older. However, for some crimes, the minimum age of liability is 14 years — this includes the offences of illegally manufacturing, processing, acquiring, possessing, transporting, and transferring of narcotics or psychotropic substances *with an intention to sell*, and the offences of theft or extortion of narcotics or psychotropic substances. For repeat offences involving the trafficking of narcotic or psychotropic substances, the severity of the sentence can be increased. For "serious" and "especially serious" crimes, the court can add the additional penalty of confiscating property. The person who has committed a crime while intoxicated by alcohol, a narcotic or other stupefying substance, is still subject to criminal liability. The degree of intoxication and its influence on the person in committing the crime are taken into account when deciding on the punishment.[1143]

Compulsory drug testing, including by law enforcement

Under Turkmen law, a person is subjected to non-voluntary drug testing if either

- an authorized state body received official information as to his or her *illegal consumption of narcotics*, or
- there is a "proven suspicion" [обоснованные подозрения] that she or he is intoxicated by narcotics.

The fact of illegal consumption of narcotics can be confirmed by evidence from witnesses, detectable signs of narcotic intoxication, the results of a physical examination and/or tests for the presence of a narcotic or psychotropic substance in the patient's bloodstream.[1144] If a person refuses to undergo drug testing, she or he can be forcibly delivered to a narcological establishment for testing. The law allows compulsory drug testing based simply on suspected drug use, even though drug use is not a punishable act under the law; this raises human rights concerns such as infringing liberty, security of the person, and privacy, and if the results of compulsory drug testing are used in any sort of criminal or administrative proceeding against the person tested, this would also infringe the right against self-incrimination.[1145]

In addition, the *Administrative Offences Code* provides that a vehicle driver for whom there are "sufficient grounds" [достаточные основания] to believe that he or she is intoxicated may be temporarily deemed unfit to drive and subject to compulsory drug testing.[1146]

Finally, the *Criminal Procedural Code* provides that in an investigation of criminal charges related to the illegal trafficking of narcotics, the investigator, if necessary, may require a "judicial-narcological examination" to identify the presence of a narcotic addiction in a person under investigation.[1147]

Groups at high risk of HIV: criminal and administrative law issues

Some other provisions of Turkmenistan's administrative and criminal legislation raise human rights concerns and create barriers to HIV and STI prevention and treatment among those who are vulnerable, by further penalizing and marginalizing those who are often already stigmatized and reluctant to seek out health services or other services.

Compulsory testing and treatment

For example, if a person is informed by public health services that he or she has STI, and evades treatment, he or she can be held administratively liable and punished by a fine.[1148] In effect, this amounts to obligatory treatment for STIs, contrary to the accepted norms that testing and medical treatment should be voluntary, based on informed consent, including out of respect for human rights.[1149] A person who has been identified as a contact (e.g., past sexual partner) of a person with a diagnosed STI is also administratively liable if he or she evades treatment; again, the offence is punishable by a fine.[1150]

Compelling disclosure of contacts

It is an administrative offence, punishable by a fine, for a person with a STI to conceal from public health authorities the source of his or her infection and the names of his or her sexual contacts.[1151] "Malicious evasion" from treatment for "venereal disease" — that is, avoiding treatment after a warning issued by a public health body — is a criminal offence punishable by a fine or corrective works for up to one year.[1152] It is difficult to see how this could be effectively enforced in any verifiable way, and according to UNODC is not currently used in practice.

Criminalizing STI and HIV transmission or exposure

Knowingly transmitting an STI is a criminal offence punishable by a fine or corrective works or imprisonment for up to two years.[1153] The national expert group was of the view that these provisions are not effective because STI testing and treatment is done for a fee and consequently, the law enforcement bodies have to make efforts to force the suspect to pay expenses for tests and treatment of STIs. The *Criminal Code* also has a provision specifically on "Transmission of the AIDS disease". It states that "knowing exposure to AIDS" of another person is an offence punishable by up to three years in prison; in cases of actual transmission, the penalty is up to five years' imprisonment.[1154] HIV transmission in relation to two or more persons or a minor carries a penalty of up to eight years' imprisonment. HIV transmission as a result of medical negligence carries a penalty of up to five years' imprisonment and suspension of the right to practice in the person's profession for up to three years. UNAIDS has recommended against such overly broad use of the criminal law to deal with HIV transmission or exposure.[1155]

Criminalizing men who have sex with men

Homosexuality remains illegal in Turkmenistan, punishable by imprisonment for up to two years, with or without an obligation to reside in a certain area for the period from two to five years.[1156] This discrimination contravenes international human rights law, including rights to non-discrimination and privacy, and is counter-productive in that it undermines HIV prevention efforts and access to health information and services among men who have sex with men.[1157] The UN Human Rights Committee has ruled that the right to privacy under the *International Covenant on Civil and Political Rights* (Article 17) is violated by such laws criminalizing consensual sex between adults of the same sex. The Committee has specifically noted that:

> …the criminalization of homosexual practices cannot be considered a reasonable means or proportionate measure to achieve the aim of preventing the spread of HIV/AIDS… [B]y driving underground many of the people at risk of infection ….[it] would appear to run counter to the implementation of effective education programmes in respect of the HIV/AIDS prevention.[1158]

1140 *Criminal Code*, Article 301.

1141 *Criminal Code*, Article 297.

1142 *Criminal Code*, Article 297(3).

1143 *Criminal Code*, Article 25. In the case of offences other than those for which intoxication is an inherent part of the offence (e.g., driving while intoxicated), to treat intoxication *per se* as an aggravating factor when sentencing arguably amounts to discrimination on the basis of health status (i.e., drug or alcohol dependence) in at least some cases, as it would amount to imposing a harsher penalty on the person convicted just because of this condition.

1144 *Law on narcotics*, Article 50.

1145 *International Covenant on Civil and Political Rights*, 999 U.N.T.S. 171 (1966), Articles 7, 9, 14, 17 ("ICCPR").

1146 *Administrative Offences Code*, Article 257.

1147 *Criminal Procedural Code*, Articles 72-75.

1148 *Code of Administrative Offences*, Article 44.

1149 UNAIDS/WHO Policy Statement on HIV Testing (June 2004).

1150 *Code of Administrative Offences*, Article 45.

1151 *Code of Administrative Offences*, Article 46.

1152 *Criminal Code*, Article 118.

1153 *Criminal Code*, Article 117.

1154 *Criminal Code*, Article 119.

1155 UNAIDS, *Policy Brief: Criminalization of HIV transmission* (August 2008).

1156 *Criminal Code*, Article 135.

1157 UNAIDS/OHCHR, *International Guidelines on HIV/AIDS and Human Rights* (2006 Consolidated Version), paras. 123-124; UNAIDS, *Policy Brief: HIV and Sex Between Men* (August 2006).

1158 UN Human Rights Committee, *Nicholas Toonen v. Australia*, Communication No. 488/1992, UN Doc. CCPR/C/50/D/488/1992 (31 March 1994), para. 8.5.

Criminalizing sex work and sex workers

Sex work, sex workers and their associates are penalized, which impedes effective HIV prevention and other health protection and promotion efforts for this vulnerable population and runs contrary to international recommendations.[1159] Both prostitution and inducing someone, for a profit, into having sexual relations with a prostitute, are administrative offences punishable by a fine or administrative arrest for a term of up to fifteen days.[1160] If a person is convicted of prostitution again within one year of a first administrative offence, this amounts to a criminal offence, punishable by a fine, corrective works for up to two years or imprisonment for up to two years.[1161] Organizing or maintaining brothels for debauchery or prostitution are crimes punishable by imprisonment for up to five years with or without confiscation of property and with or without obligatory residence in a certain district for two to five years).[1162] Procuring a prostitute's sexual services for someone is a crime punishable by imprisonment for up to five years and/or confiscation of property;[1163] pimping someone engaged in prostitution is a crime punishable with imprisonment for a term of two to six years and/or confiscation of property.[1164] Subsequent offences attract a stricter punishment (imprisonment for a term of three to eight years).

1159 UNAIDS/OHCHR, *International Guidelines on HIV/AIDS and Human Rights*, Guideline 4, para 21(c).

1160 *Administrative Offences Code,* Articles 176(1) and 176(2).

1161 *Criminal Code*, Article 138.

1162 *Criminal Code*, Article 140.

1163 *Criminal Code*, Article 141 (сводничество).

1164 *Criminal Code*, Article 142.

4. HEALTH SERVICES

The *Constitution of Turkmenistan*[1165], the *Law on health protection*,[1166] the *Law on refugees*[1167], the *Law on migration*,[1168] the *Law on the legal status of foreign citizens,*[1169] the *Law on prevention of HIV,*[1170] and the *Law on narcotics* all provide various aspects of a right to health protection, including free use of the network of official public health bodies by citizens, foreign citizens, persons without citizenship and refugees. Access to primary and emergency health care is provided based on the individual's place of residence. For those who are unemployed or without a specific residence, provision of free health services is carried out in accordance with the general practice in the place where the application was made. Legally, migrants and refugees have access to treatment equal to that of citizens of Turkmenistan.

Free use of the network of official public health services provides: emergency medical aid; medical services to those sick with tuberculosis or mental, oncological or infectious diseases; services for those with drug dependence; and services for pregnant women and children under the age of 16. For people with HIV or AIDS and people who use drugs, treatment of these diseases and accompanying hepatitis treatment is carried out on a free basis. In the case of paid health care services, the health insurance policy provides for 50% coverage of the cost of treatment and 90% of the cost of medical products (e.g., prescribed medicines).

According to the national expert group, the use of narcotic drugs or psychotropic substances is not an acceptable reason to deny someone treatment for hepatitis, tuberculosis, HIV or drug dependence. Partnerships exist between the medical institutions providing treatment of drug dependence, tuberculosis and hepatitis C infection. At the time of the national expert group's report, there were no people receiving ARV treatment in Turkmenistan.

4A. DRUG DEPENDENCE TREATMENT

Treatment of those with alcoholism or dependence on drugs or inhalants is considered part of psychiatric assistance services set out by law, which includes mental health examinations and the diagnosis of psychiatric disorders, along with treatment, care and medical and social rehabilitation.[1171] According to the national expert group, narcological centres providing "anonymous" treatment operate in the capital city Ashghabat and in every province. In all, the country has eight such treatment sites, providing services to both men and women. In addition, in Ashghabat and all provinces, there are also women-only sections in hospitals for treatment of narcotic addiction. According to the national expert group, during nine months of 2007, drug dependence treatment was supplied to 17,741 patients, including 1493 women.[1172] There were 1995 people registered as having narcotic addiction who also had diagnosed hepatitis. In total, there were 32,969 people on narcological registry of Turkmenistan at the time of the national expert group's report.

In addition to the substantive provisions related to drug dependence treatment in the *Law on psychiatric assistance*, the *Law on narcotics*, and the *Law on health protection*, standards for drug dependence treatment are provided in an interdepartmental order of the Ministry of Health and Medical Industry.[1173] The state guarantees provision of free drug dependence treatment and medical and social rehabilitation to persons with narcotics addiction. The treatment of drug dependence can include medication-assisted detoxification, outpatient treatment and rehabilitation activities. Theoretically narcological assistance could

1165 *Constitution of Turkmenistan*, (26 September 2008), Article 35.

1166 *Law of Turkmenistan on health protection,* [Об охране здоровья граждан], No. 157-II, 14 December 2002.

1167 *Law of Turkmenistan on refugees*, [О беженцах] No. 231-I, 12 June 1997,

1168 *Law of Turkmenistan on migration*, [О миграции] No.30-III, 7 December 2005.

1169 *Law on legal status of foreign citizens,* [О правовом положении иностранных граждан], No. 901-XII, 8 October 1993.

1170 *Law of Turkmenistan "On prevention of the disease caused by the human immunodeficiency virus (HIV)"* [О профилактике заболевания, вызываемого вирусом иммунодефицита человека (ВИЧ-инфекция)], No. 78-II, 7 July 2001.

1171 *Law on psychiatric assistance* [О психиатрической помощи], No. 869-XII (1 October 1993), Article 1.

1172 Information provided by national expert group for September 2007.

1173 Ministry of Health and Medical Industry, Order No. 300 (14 October 2000).

be provided by both private and public health care facilities. At present treatment of drug dependence is conducted on the base of public health care facilities only.

As a general matter, the medical confidentiality of persons who have voluntarily sought drug dependence treatment from narcological institutions is to be protected. However, data on a person receiving treatment can be disclosed to law enforcement bodies in the event of an official inquiry by such bodies; in addition, health care workers are obliged to transfer data on those identified as drug users to local narcological experts and to report cases of suspected overdose.[1174] According to the information provided by the national expert group, naloxone, an opioid antagonist used for emergency treatment of overdoses, is considered a poisonous medical product subject to control. Naloxone is not registered in Turkmenistan and is not used for medical purposes.

Compulsory drug dependence treatment

Ordinarily, medical interventions, including drug dependence treatment, are provided upon a person's voluntary application or with his or her consent (or, in the case of minors, consent by parents or lawful representative).[1175] However, according to the *Law on health protection*, medical intervention without consent is allowed in the cases of:

- persons "suffering from diseases representing a danger to other people";
- persons "suffering from grave mental disorders"; and
- persons who have committed "socially dangerous acts" or who are suspected of those.[1176]

According to this law, the list of diseases representing a danger to other people, and the list of institutions of public health services for medical aid to treat patients with various diseases, is approved by the Cabinet of Ministers of Turkmenistan.[1177] As of December 2008, the list of especially dangerous infectious diseases included such diseases as plague, cholera, hemorrhagic fevers and HIV.[1178]

In addition, under the *Law on narcotics*, a court may impose involuntary medical interventions on anyone diagnosed with "narcotic addiction", if he or she evades medical supervision and treatment and continues to use drugs.[1179] Bodies from either law enforcement or the public health services may seek such a court order.[1180] According to the law, in the case of a minor at least 16 years of age or older who evades compulsory drug dependence treatment or who continues to use drugs after such treatment, a court may order the minor to be detained in a special medical and educational facility of the public health services for a term of six months to two years.[1181] According to the information provided by UNODC, no such facilities for minors currently exist. In practice minors undergo treatment in a regular unit in a narcological facility, or if convicted with criminal offence - in correctional institution.

Persons convicted of a criminal offence are subject to compulsory drug dependence treatment in prison, and after release, if treatment needs to be continued, in medical institutions in accordance with the general practice (see further details below).

As is evident from the legislative provisions just described, compulsory medical interventions can regularly be applied to persons who use drugs. International organizations underline the principle that drug

1174 Ibid.

1175 *Law on narcotics*, Article 52 ("Narcological assistance to persons with narcotic addiction").

1176 *Law on health protection*, Article 28.

1177 *Law on health protection*, Article 39.

1178 Ministry of Health and Medical Industry, "On sanitary protection of the territory of Turkmenistan", Order No. 116 of 26 December 1995. This Order was prepared on the basis of Order No. 18 (12 December 1995) of the Vice-Chairman of the Cabinet of Ministers. In addition, the *Sanitary Code of Turkmenistan* (adopted 19 May 1992) regulates maintenance of the sanitary-and-epidemiologic well-being, including prevention and distribution of infectious diseases.

1179 *Law on narcotics*, Article 42; *Criminal Code*, Article 94.

1180 This authority derives from a joint order of the Ministry of Health and Medical Industry and the Ministry of Internal Affairs, "On detection, registration and enforcement of forced measures to persons suffering from narcotic addiction and inhalant addiction", Order No. 163/134 (30 August 2006).

1181 Presidium of the Supreme Council of the Turkmen Soviet Socialist Republic, "On modifications and additions in some acts of the Turkmen Soviet Socialist Republic and the approval of the Statute of medical-educational dispensaries for those sick with narcotic addiction", Decree No. 918-XI (18 August 1987).

dependence treatment should generally be voluntary.[1182] As a general proposition, compulsory medical treatment violates human rights, including to liberty, security of the person and privacy,[1183] and should be applied only in extreme, clearly defined cases with a view to preventing a person from causing imminent, serious harm to himself or herself or to others.

Substitution therapy

Opioid substitution treatment (OST) is a well-studied, effective method of managing and treating opioid addiction used widely in many jurisdictions, and is recognized as a key element of HIV prevention among people who inject drugs.[1184] International drug control treaties ratified by Turkmenistan do not prevent the use of medications such as methadone and buprenorphine as OST,[1185] and they are recognized by the World Health Organization as "essential medicines".[1186]

OST programmes do not exist in Turkmenistan, but some legislative provisions allow for its introduction. For example, methadone is included on the list of narcotics and psychotropic substances for which limited distribution, as a medical preparation, is permitted, subject to certain controls.[1187] Therefore, methadone can be used for medical purposes on the basis of a prescription made on special forms.[1188] Prescription of narcotics and psychotropic substance (which would include medications used for OST) by medical workers of private health care facilities is forbidden.

Registration of people who use drugs

Persons with drug dependence are subject to a system of extensive registration by the state, being registered with both law enforcement bodies and treatment-and-prevention institutions of the state system of public health services.[1189] Data in such registries is maintained by the narcological service of the Ministry of Health and Medical Industry, and by local police forces under the Ministry of Internal Affairs.

Inclusion in the narcological database can temporarily preclude a person from being eligible for some kinds of employment and activities seen as higher risk. That decision is made by a medical commission; it may be appealed through a judicial procedure.[1190] Registration as a person who uses drugs can also entail a number of other restrictions of the rights, such as:

- denial of a driving license;
- restriction on parental rights or eligibility to adopt — according to the *Code on Marriage and Family*, one or both parents can be deprived of parental rights on the basis of chronic alcoholism or drug dependence;[1191] and
- denial of the right to vote, if the person using drugs has been deprived of legal capacity in a judicial procedure — which the court may do if the person, as a result of drug use, puts his or her family in a grave financial situation.[1192]

The *Law on migration* establishes that drug dependence, is a basis for denying a visa or residence permit to a foreign citizen or person without citizenship. These are also grounds on which a residence permit may be cancelled.[1193]

1182 UNODC and WHO, *Principles of Drug Dependence Treatment: Discussion Paper* (March 2008).

1183 *International Covenant on Civil and Political Rights*, 999 U.N.T.S. 171 (1966), Articles 7, 9 and 17; *Universal Declaration of Human Rights*, UN General Assembly Resolution 217A (III), UN Doc. A/810 (1948), Articles 3 and 12.

1184 WHO/UNODC/UNAIDS, *Position Paper: Substitution maintenance therapy in the management of opioid dependence and HIV/AIDS prevention*, 2004.

1185 UN International Drug Control Programme (UNDCP), *Flexibility of Treaty Provisions as Regards Harm Reduction Approaches*, Decision 74/10, E/INCB/2002/W.13/SS.5 (30 September 2002).

1186 WHO, *WHO Model List of Essential Medicines*, regularly updated, online: http://www.who.int/medicines/publications/essentialmedicines.

1187 President of Turkmenistan, "On approval of lists of narcotics, psychotropic substances and precursors," Decision No. 9192 (13 November 2007), Appendix No.2.

1188 *Law on narcotics*, Article 33 ("Release of narcotics and psychotropic substances to individuals for medical purposes").

1189 Ministry of Health and Medical Industry of Turkmenistan, Order No. 300 of 14 October 2000.

1190 *Law on narcotics*, Article 53.

1191 *Code on Marriage and Family*, Articles 70 and 115.

1192 *Law on narcotics*, Article 53; *Civil Code of Turkmenistan*, Articles 26(1) and 27(1).

1193 *Law of Turkmenistan on migration*, Article 15.

4B. HIV/AIDS PREVENTION AND TREATMENT

HIV prevention education

The HIV prevention service of Turkmenistan consists of six centres: the National Centre in Ashgabat and five provincial centres of HIV prevention, which provide counselling and testing for HIV and telephone hotlines. Currently, measures of HIV prevention in Turkmenistan consists of information and education activities among youth and the general population, and the distribution of condoms by official bodies and public organizations. Information about HIV is included into school curricula, and is available at women's counselling agencies and family and children's centres. These are no systematic evidence based measures of HIV prevention specifically tailored to people who inject drugs and prisoners in Turkmenistan.

HIV testing

The *Law on prevention of HIV* provides the right of citizens of Turkmenistan, foreigners and stateless persons living or in the state's territory to have access to "voluntary, confidential, anonymous HIV testing."[1194] All persons getting tested for HIV are to receive pre- and post-test counselling.[1195] The legislation does not explicitly require informed consent to HIV testing. Under the *Law on migration*, citizens of Turkmenistan, foreigners and stateless persons are subject to mandatory HIV testing in the presence of "epidemiological indications".[1196] Foreigners and stateless persons who test HIV-positive are denied a visa or residence permit on this basis, and are subject to having a residence permit cancelled and to administrative deportation from Turkmenistan.[1197] (STIs and drug dependence are other grounds for denial of a visa or residence permit).[1198] In addition, obligatory testing for HIV is applied to:

- donors of blood, biological liquids, organs and tissues;
- people who use drugs and persons receiving treatment for drug dependence;
- persons diagnosed with tuberculosis, hepatitis or STIs;
- prisoners;
- sex workers;
- foreign citizens if their stay in Turkmenistan exceeds three months;
- pregnant women;
- newborns if the mother is HIV-positive or based on clinical indications; and
- workers of bodies of the public health services, if their work is connected with blood.[1199]

A regular medical examination, including HIV testing, is also done for medical personnel who carry out diagnostic tests for HIV, provide medical care and preventive interventions to persons with HIV and AIDS, or have contacts with blood and other materials from infected persons.[1200]

According to international standards, an HIV test should be done on a voluntary basis only; mandatory testing is justified only for donors of blood, organs or tissues.[1201]

Treatment for people living with HIV

The treatment of HIV infection *without the consent* of the patient or his or her lawful representatives is allowed on the basis of the *Law on health protection of citizens*, which establishes that treatment may be imposed on persons suffering from "diseases representing a danger to others" (which has been defined to include HIV) or "suffering grave mental disorders", and on persons who have committed socially dangerous acts.[1202]

1194 *Law on prevention of HIV,* Article 5. The wording of the article states simultaneously that testing is "anonymous" and "confidential"; whether there is access to any testing that is entirely anonymous remains unclear.

1195 Instruction of the Ministry of Health and Medical Industry, "*On Physical Examination on HIV-infection and detection of HIV-infected and those sick with AIDS in Turkmenistan*" (14 January 2004), para. 5.

1196 *Law on prevention of HIV,* Article 6.

1197 *Law on migration*, Article 18: a foreign citizen is subject to administrative deportation in cases where it is required to protect the health and or morals of the population, or to protect the rights and legitimate interests of citizens of Turkmenistan and others.

1198 *Law on migration*, Articles 15, 16 and 18; and Government Resolution. No. 5833 "Status of foreign citizens and stateless persons on the territory of Turkmenistan" [Положение иностранных граждан и лиц без гражданства на территории Туркменистана], 2002.

1199 Information presented by the expert group of Turkmenistan.

1200 *Law on prevention of HIV,* Article 11.

1201 UNAIDS/WHO Policy Statement on HIV Testing (June 2004).

1202 *Law on health protection of citizens*, Article 28(1). For the list of especially dangerous infectious diseases (including plague, cholera, hemorrhagic fevers and HIV), see: Ministry of Health and Medical Industry, "On sanitary protection of the territory of Turkmenistan," Order No.116 of 26 December 1995, prepared on the basis of Order No. 18 of the Vice-Chairman of the Cabinet of Ministers of Turkmenistan of 12 December 1995.

According to the *Law on prevention of HIV*, people with HIV receiving outpatient treatment are entitled to free medications, including antiretroviral (ARV) therapies.[1203] However, as of this writing in December 2008, ARV therapy is not available in Turkmenistan.[1204] ARV medicines are not included in the List of Essential medicines in Turkmenistan. Theoretically people living with HIV and AIDS are eligible to receive reimbursement for costs connected with travel to and from the place of treatment from the local institution of the public health services. Parents (or other lawful substitute) whose children under 14 live with HIV, or are sick with AIDS, have the right to a joint stay with them in a hospital while receiving the temporary disability allowance. One of the parents (or other lawful substitute), who takes care of a child under 16 recognized as being disabled on the basis of HIV or AIDS has the right to have the period of care included in the pension record. Persons with HIV or AIDS under the age of 16 have the right to a monthly allowance. In 2007 the Ministry of Health of Turkmenistan approved the new standards of medical care of patients with tuberculosis, that include standards on conducting counselling and treatment of patients with tuberculosis and HIV. Protocols for the prevention of vertical transmission of HIV and HIV post-contact prevention have been developed, and are presently (April 2009) in the process of approval.

Patients' rights, including confidentiality

The right of the patient to health protection is guaranteed by the state, and includes, *inter alia*: respectful and humane treatment from health workers; mitigation of pain caused by disease; confidentiality of information on the patient's application for medical aid, state of health, diagnosis and other data from examination and treatment; and voluntary consent or refusal from medical intervention.[1205] The law states that persons with mental disorders keep all rights and freedoms of citizens.[1206]

Information on the fact of applying for medical aid, a patient's state of health, the diagnosis of disease and other data received during examination and treatment, constitute "medical secrets" protected by law.[1207] Breaching a patient's confidentiality by disclosing medical or other personal information, including information related to HIV status, can attract criminal liability.[1208] In addition, the *Law on prevention of HIV* specifically protects the privacy of people living with HIV by imposing a legal obligation on workers of institutions of the public health services to keep information on patients' HIV status confidential.[1209]

Disclosure of confidential health information without the consent of the patient (or his or her lawful representative) is allowed in the following circumstances:

- in order to examine and treat a person who is not capable, because of his or her health condition, of expressing his or her will;
- in case of risk of distribution of infectious diseases, mass poisonings and injuries;
- upon receipt of a written demand from bodies of inquiry or investigation, the Office of the Public Prosecutor or a court, in connection with an investigation or court proceeding;
- to the parents or lawful representatives in the case of providing medical aid to a minor under the age of 16; and
- in circumstances where there are sufficient grounds to believe that illegal acts have caused harm to the health of others.[1210]

A report on the results of HIV blood tests is provided quarterly to the Ministry of Health and Medical Industry and to the State Committee of Turkmenistan on Statistics. Confidentiality of the information is ensured by the employees of the HIV prevention centres under the Ministry of Health. The access rights to such data are provided to heads of the HIV prevention centres, heads of laboratories, departments of epidemiology within the Ministry of Health.

A patient (or his or her lawful representative) can file a complaint about an infringement of rights directly to the official of the health care facility where medical aid is provided, to a higher body or to a court.[1211]

1203 *Law on prevention of HIV,* Article 10.

1204 Information provided by national expert group.

1205 *Law on health protection*, Article 25.

1206 *Law on psychiatric assistance*, Article 5.

1207 *Law on prevention of HIV,* Article 9; *Law on health protection*, Article 60.

1208 *Criminal Code*, Article 114.

1209 *Law on prevention of HIV,* Article 9.

1210 *Law on health protection*, Article 60.

1211 *Law on health protection*, Article 25(3).

5. PRISONS

In Turkmenistan, the Ministry of Internal Affairs has jurisdiction over correctional institutions. In total, the country has 17 such institutions: one prison; one "general security", three "strict security" colonies, one "special security" colony and one settlement-type colony (operated at a less strict security level than other colonies), all of which house adult men only; one colony for women (encompassing all different levels of security); one colony for minors; one colony specifically for former law enforcement personnel; one colony for medical treatment of male prisoners; five pre-trial detention centres; one medical-labour facility (for compulsory treatment of alcohol and drug dependence).[1212]

The national expert group reports that persons sentenced for narcotics-related crimes of "medium seriousness" usually serve time in general security colonies. According to figures from national expert group, as of 2007, 19% of prisoners in Turkmenistan's penitentiary system were serving sentences for drug-related offences.[1213] The national expert group states that there are no narcotics in any of the penitentiary institutions.

According to the *Corrective Labour Code*, food, clothes, and necessary items for personal hygiene are provided free of charge.[1214] Those prisoners who work are charged for expenses related to their maintenance in prison. Prisoners have the right to buy food and basic personal necessities using credit earned through prison work. Prisoners with disabilities of the "first category" and "second category" (i.e., conditions with serious impairments), and those released from work based on sick leave, as well as pregnant women, nursing mothers and minors, can get food and basic personal necessities using money received as transfers from family and friends outside of prisons.

Health care in the correctional system

According to the statistical data provided by the national expert group, no cases of HIV or hepatitis C were registered in any institution of the penitentiary system, but 719 convicts had diagnosed tuberculosis (2006 data).

Total documented cases of diagnosed narcotic addiction, tuberculosis and mental disorder in Turkmen correctional institutions[1215]

	2005	2006
Narcotic dependence	3318	2999
Tuberculosis	876	719
Mental disorders	31	28

The Medical Service of the Penitentiary Department within the Ministry of Internal Affairs is responsible for medical services in the institutions of the penitentiary system and pre-trial facilities, based on needs identified and submitted by correctional facilities and pre-trial facilities.[1216] The national authorities state that no complaints have ever been received from prisoners regarding the supply of medical accessories or medicines.

According to the *Law on health protection*, prisoners and people in pre-trial detention have the right to health care, including in the public health care facilities, and pregnant women have the right to pre-natal and natal care.[1217]

1212 Information reported by the national expert group from Turkmenistan. This closed residential facility for compulsory treatment of alcohol and drug dependent persons and their re-education through mandatory labour (for non-offenders) exists under the Ministry of the Interior. Joint Decree of the Ministry of Health and Medical Industry and the Ministry of Internal Affairs "On detection, registration and enforcement of forced measures to persons suffering from drugs and psychoactive substances dependence", No.163/134 (30.08.2006).

1213 According to the national expert group, this 19% figure breaks down as follows: 3.12% in general security colonies; 9.41% in strict security colonies; 2.27% in the one special security colony; and 4.2% in the one prison.

1214 *Corrective Labour Code of Turkmenistan* [Исправительно-трудовой кодекс], 1971, Article 74.

1215 Data shown in this table was provided by the national expert group.

1216 Ministry of Internal Affairs, Order "*On medical care for persons contained in investigative insulators, correctional facilities and hospital of the Penitentiary within the Ministry of Internal Affairs of Turkmenistan*" (17 July 2002).

1217 *Law on health protection*, Article 23.

HIV prevention and treatment

According to the national expert group, currently HIV prevention in prisons consists of compulsory HIV testing and some measures to provide education and information. The "*National Programme on Prevention of HIV/AIDS/STDs in Turkmenistan for 2005-2010*", noted above, provides for carrying out trainings for prisoners on HIV/STI prevention and development of high moral standards. Such initiatives are implemented by medical workers of the institutions and state organizations — for example, the AIDS Centre which periodically carries out educational session on HIV/AIDS for prisoners. According to the national expert group, over a 9-month period in 2007, 6 seminars for medical workers and 47 presentations on HIV/STI prevention were delivered to law-enforcement personnel and prisoners. In total, 67 hours have been spent for educational work on HIV, reaching about 24,000 people. As of this writing, there are no plans to involve NGOs in HIV prevention efforts with prisoners. The national expert group has observed that HIV testing which is not accompanied by pre-test and post-test counselling, and testing which is not provided on a voluntary basis, can lead to an opposite effect, and push people away from seeking medical services. The national experts therefore recommend that the government introduce real and effective measures of prevention of HIV in the penitentiary system, and to ensure that testing is done on a voluntary basis, with pre-test and post-test counselling.

Drug testing and treatment of drug dependence

Drug testing is compulsory for prisoners in Turkmenistan. Prisoners with drug dependence receive treatment in medical units of the correctional facilities.[1218] People with drug dependence who are serving a term for committing administrative offences receive treatment in a treatment and labour facility. Minors aged 16 or older who are drug-dependent and are evading treatment are subject to court-ordered compulsory treatment in medical-educational facilities for a term of six months to two years.[1219] The primary goal of the medical-educational facilities is treatment and re-education of those suffering from drug dependence. For these purposes, theoretically these institutions organize special treatment, in isolation, and general educational and vocations training.

Prisoners who are subject to compulsory drug dependence treatment are hospitalized for at least 60 days and then receive supportive treatment on an out-patient basis, in combination with "labour therapy". According to the national expert group, an "optimal" term of compulsory treatment in the system of penitentiary is two years. During the first year, prisoners with drug dependence are seen by psychiatrists and narcologists not less than once a month; during the second year, not less than once every two months. Supportive out-patient treatment is provided every 3 months for 3-4 weeks at a time. According to the law, if, by the time of release from imprisonment, the treatment is not finished, the administration of the correctional institution files a petition to a court, accompanied by a medical certificate, for an order to continue compulsory treatment of the person in a medical institution outside of prisons.[1220]

There are no programmes of rehabilitation for the pre-release and post-release period. Three months prior to a prisoner's release, correctional institution personnel are required to notify the local police department responsible for the area to which the person will be directed upon release; that notice also indicates that employment and housing assistance needs to be provided to the person upon release.[1221]

1218 Treatment of drug dependence of prisoners is regulated by the *Corrective Labour Code* and orders of the relevant ministries: Ministry of Internal Affairs, "On medical care of persons contained in investigatory insulators, correctional facilities and hospital of the UIN of the Ministry of Internal Affairs of Turkmenistan", Order No. 118 (17 July 2002), and Ministry of Health and Medical Industry, "Treatment and supervision of alcoholics and addicts", Order No. 300 (5 June 2000).

1219 Presidium of the Supreme Council of the Turkmen Soviet Socialist Republic, "On modifications and additions to some acts of the Turkmen Soviet Socialist Republic and the approval of the Statute of medical-educational dispensary for those sick with narcotic addiction", Decree No. 918-XI (18 August 1987).

1220 *Corrective Labour Code* (1971), Article 76.

1221 Ministry of Internal Affairs, "On approval of the instruction on assistance in employment and housing to the persons who have served their term or after release from medical-labour preventive term, and the reporting procedure to law-enforcement bodies", Order No. 79 (23 April 2003).

6. DISCRIMINATION AND RESTRICTION OF RIGHTS

According to the Constitution of Turkmenistan, the state guarantees equality.[1222] The *Criminal Code* provides for criminal liability for direct or indirect infringement or restriction of rights and freedoms based on sex, race, nationality, language, origin, financial or official position, residence, religion, belief, or membership in public associations.[1223] Turkmen legislation does not currently include any specific provisions forbidding discrimination based on health status generally. However, the law prohibits an employer from unreasonably refusing to employ someone, or unreasonably dismissing someone from work, on the basis that he or she has HIV or AIDS.[1224]

Despite the general prohibition on discrimination in Turkmen law, there are a number of areas in which the law itself discriminates against people living with HIV or in other ways that affect efforts to address HIV among vulnerable populations (in particular, people who use drugs and prisoners). The following should be noted:

- *Employment restrictions against drug users*: People with drug dependence can be temporarily deemed illegible to perform certain kinds of jobs and activities considered high risk — that is, work or activities connected with the operation and use of certain objects, equipment and substances where there is a greater risk of causing harm to people or the environment (e.g., pilots, drivers, railway personnel, and construction workers). This restriction can be imposed for up to three years, but may also include subsequent re-examination. The decision on imposing such restrictions is made by a medical commission.[1225] The decision to deem a person ineligible to perform certain kinds of jobs or activities can be appealed against in the court in an order established by the legislation. After a person is removed from the registry, this restriction is removed.[1226]

- *Discrimination in immigration and residence*: As noted above, according to the *Law on migration*, HIV infection, venereal diseases and narcotic addiction are bases for denying a foreigner a visa or residence permit in Turkmenistan,[1227] or for canceling a residence permit and deporting a non-citizen.[1228]

- *Denial of voting rights*: The right to participate in elections is denied to prisoners and to persons who are being held in custody as preventive punishment pursuant to an order under Turkmen law.[1229]

- *Restriction of family rights*: According to the *Code of Marriage and Family of Turkmenistan*, in cases of concern about child abuse or neglect, parents can be deprived of parental rights if they are "chronically dependent on alcohol or drugs".[1230] This suggests that the health condition of alcoholism or drug dependence could be assumed to amount *per se* to a basis for depriving parents of their children.

According to principles well established in international human rights law, limitations or infringements on human rights may only be justified in accordance with clear standards.[1231] One key principle is that of non-discrimination, including based on health status. It will be the very rare case in which denying certain rights or benefits to entire classes of persons based on their health status (e.g., diagnosis with HIV infection or drug dependence) will be justifiable. Rather, discriminating in employment or denying parental rights should require case-by-case justifications, based on an assessment of individual circumstances, rather than based on inaccurate, generalized assumptions about a person's capacity to perform the functions of a job or to be a suitable parent based on health status.

1222 *Constitution of Turkmenistan*, Article 19.

1223 *Criminal Code*, Article 145.

1224 *Law on HIV*, Article 10.

1225 The Cabinet of Ministers approves the "List of medical counter-indications for realization of some kinds of professional work and the activity connected with sources of high risk".

1226 *Law on narcotics*, Article 53.

1227 *Law on migration*, Article 15.

1228 *Law on migration*, Article 16.

1229 *Law on elections of deputies of the Mejlis of Turkmenistan* (25 October 2005); *Law on elections of members of Gengeshes* (25 October 2005); *Law on elections of members of Etrap, City People's Councils* (25 October 2005); *Law on elections of members of provincial councils* (25 October 2005).

1230 *Code on marriage and Family of Turkmenistan*, 25 December 1969, Article 70.

1231 UN Economic and Social Council, *Siracusa Principles on the Limitation and Derogation Provisions in the International Covenant on Civil and Political Rights*, UN Doc. E/CN.4/1985/4, Annex (1985).

7. CONCLUSIONS AND RECOMMENDATIONS

While Turkmenistan has programmes on HIV prevention, national legislation and policy includes numerous areas in which there is room for reforms to improve the law in order to pay more attention to the rights of people living with HIV or vulnerable to HIV (in particular prisoners and people who use dugs), thereby reducing their stigmatization and marginalization and their vulnerability to HIV and facilitating their access to medical services. Introducing such reforms is consistent with international human rights norms and will protect public health more broadly. The recommendations below are aimed at addressing issues identified by the national expert group of Turkmenistan and by the project's technical advisors. Suggested language of legislative amendments is shown in shaded boxes.[1232]

National programmes and strategies

Recommendation 1: Ensure attention to and involvement of people living with HIV and vulnerable groups

In the interests of being more inclusive, and hence better informed and more effective, national programmes and strategies on both HIV/AIDS and on drugs should explicitly guarantee:

- attention to HIV prevention, care, treatment and support for vulnerable groups, including people who use drugs and prisoners, among others;
- an explicit commitment to addressing discrimination against people living with HIV and members of vulnerable groups, and to respecting and protecting the confidentiality of people living with HIV;
- the involvement of and closer cooperation with civil society organizations, people living with HIV, people who use drugs, and members of other vulnerable groups in development and implementation of national programmes and strategies;
- better coordination of the activities of state and non-state stakeholders;
- in the case of the national programme against AIDS, better financing for the programme's activities; and
- greater use of a large number of experts, with improved qualifications, on HIV/AIDS and related fields.

The involvement of civil society organizations, persons living with HIV and persons who use drugs in the work of bodies on HIV/AIDS could be strengthened by adding a specific legislative provision mandating this involvement in the *Law on prevention of HIV*.

Recommendation 2: Ensure harm reduction measures are part of the response to HIV and to drugs

The National Programmes addressing AIDS and drugs, as well as the *Law on HIV prevention*, omit any reference to harm reduction measures, yet these are critical to an effective response to HIV among people who use drugs. It is recommended to increase access to quality drug dependence treatment, and introduce such measures as opioid substitution treatment (OST), needle and syringe programmes (NSPs), and outreach programmes (including peer-to-peer programmes). In addition, the Government can strengthen its response to HIV by consulting more actively with civil society in discussing and studying the effectiveness and efficiency of such measures in the country as they are introduced.

1232 In many instances, the wording of proposed legislative amendments is adapted from model provisions in Legislating for Health and Human Rights: Model Law on Drug Use and HIV/AIDS (Toronto: Canadian HIV/AIDS Legal Network, 2006), online in both English (www.aidslaw.ca/modellaw) and Russian (www.aidslaw.ca/modellaw-ru). This publication, consisting of a series of 8 modules on different issues, was used as a key reference by UNODC, national expert groups and the project's technical advisors during the review and assessment of national legislation in the countries participating in the project. Where relevant, citations below are to specific modules of that resource; the accompanying text and commentary to be found in those modules may be useful to legislators and policy-makers in implementing these recommendations.

Recommendation 3: Remove criminal and administrative liability for possession of small quantities of drugs for personal consumption

Those who are most negatively affected by harsh criminal penalties for drugs, particularly criminal penalties for possessing drugs for personal use, are people with addictions. The national expert group has identified that local authorities are interested in humanizing the law in this area, particularly in the case of possession of small amounts of drugs without an intention to sell. The national expert group recommends the following:

- The Government should begin consultations with key persons with a view to identifying ways in which the law can be reformed in this area. Such consultation should include civil society organizations working in HIV prevention and otherwise providing health services to people who use drugs, as well as people who use drugs themselves to the extent feasible.

- The Government should investigate the experiences and approaches taken by other countries in tempering criminal or other liability for possession of drugs, such as introducing in law the concept of a small quantity for personal consumption, and providing alternatives to criminal liability and punishment for such possession (including encouraging treatment for drug dependence where warranted), as is allowed under international treaties.

In implementing reforms to remove criminal and administrative liability for possession of quantities for personal use, the Government should enact a provision such as the following in statutes such as the *Law on narcotics,* the *Code of Administrative Offences* and the *Criminal Code* (or even all three):[1233]

Decriminalization of possession without intention to sell
Notwithstanding anything in this or any other statute, the possession and use of a [small quantity] of a narcotic or psychotropic substance listed in [relevant schedule/list] for personal use does not constitute a criminal offence.

Recommendation 4: Remove prohibition of drug use from the law

Currently, drug use *per se* is prohibited according to the Law on drugs (however there is no penalty in Administrative or Criminal code). This has the effect of stigmatizing people who are dependent on drugs; creates barriers to seeking out health services, including treatment for drug dependence. A preferable approach, more consistent with human rights and with promoting and protecting health, would be to not punish people for a health condition, but to take measures to facilitate their voluntary access to health services that are respectful and humane. It is recommended to remove Article 49 prohibiting drug use from the *Law on narcotics*.

Recommendation 5: Provide alternatives to imprisonment for some drug offences

The national expert group has recognized that prisons are not well equipped to ensure appropriate HIV prevention and care, including for people who use drugs or to ensure drug dependence treatment for prisoners who need it. The national expert group has put forward a number of recommendations for improving the response to HIV and to drug dependence in the prison setting (see "Prisons" section below). However, the national expert group has also recognized that one important measure will also be to reduce the frequency with which people who use drugs go to prison. Implementing Recommendation 3 above is one important way to achieve this, by removing criminal liability at least in the case of possession of small quantities of drugs for personal use.

1233 See *Legislating for Health and Human Rights: Model Law on Drug Use and HIV/AIDS*, Module 1: Criminal law issues, pp. 18-21. If the decision were made also to remove administrative liability for possession of small quantities for personal use, then this provision could be changed to refer to "depenalization" and could explicitly state that such possession also does not constitute an administrative offence. The provision could be added to the *Administrative Offences Code* as well.

In addition to taking such a step, to the extent that certain acts related to drugs remain criminal offences, at least the approach to punishing such crimes can be changed to reduce the use of imprisonment, with all the human and financial costs and harm to public health that imprisonment carries. The national expert group has recommended amendments to the *Criminal Code* to implement alternatives to imprisonment for non-violent offences related to drugs (without an intention to sell). Such alternatives are clearly permissible under international drug control treaties, which explicitly allow States Parties to those treaties to include, in their domestic legislation, *alternatives* to conviction and incarceration for drug offences.[1234] Creating alternatives to imprisonment could be achieved by enacting one or the other (but not both) of the following provisions:

Alternatives to prosecution and imprisonment for certain drugs offences

Option 1: Referral to quasi-judicial commission

(1) The sections below apply to the following offences involving a narcotic or psychotropic substance when those offense are committed in circumstances that do not involve violence and there is no accusation of an intent on the part of the accused person to sell said substance: i.e. those under Article 43 (1) of the *Code of Turkmenistan on Administrative Offences* and Articles 293 and 298 of the Turkmenistan's *Criminal Code*:

- Illegal acquisition or possession of narcotics *in small quantities without an intention to sell*
- Illegally acquiring or possessing narcotics or psychotropic substances *in a small quantity, without an intention to sell*, when committed for the second time within a year
- Illegally manufacturing, processing, acquiring, possessing, transporting or transferring a narcotic or psychotropic substance, *without an intention to sell*

(2) The offences referred to in section (1) shall be processed, and penalties applied if applicable and necessary, by a quasi-judicial commission ("the Commission").

(3) The Commission shall include a legal expert, as well as other experts such as medical practitioners, psychologists, social service workers or others with appropriate expertise in the field of drug dependence.

(4) The rules of procedure governing the proceedings of the Commission, including the admissibility of medical evidence, shall be determined by the Ministry of Internal Affairs and the Ministry of Health and Medical Industry.

(5) In arriving at the appropriate penalty for a person apprehended by police for the offences referred to in Section (1), the Commission shall consider:
(a) the seriousness of the act;
(b) the relative degree of fault;
(c) the type of substance involved in the offence;
(d) the public or private nature of the offence and, if relevant, the location of the offence;
(e) the personal circumstances, namely economic and financial, of the offender; and
(f) whether the offender is an occasional, habitual or dependent drug user.

(6) The Commission may apply penalties including, but not limited to, one or more of the following:
(a) a notice of caution;
(b) a fine in proportion to the amount of the narcotic or psychotropic substance possessed for personal use, taking into account the economic situation of the alleged offender;
(c) restriction on travel or attendance in certain places;[1235] and
(d) suspension of driving or professional licences.

1234 *Single Convention on Narcotic Drugs*, 1961, UN, 520 UNTS 331, as amended by the 1972 Protocol, Article 36(2); *Convention on Psychotropic Substances*, 1971, UN, 1019 UNTS 175, Article 22; *Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances,* 1988, Article 3(4).

1235 Note that it will be important to avoid an order that prohibits the person from entering an area where important health services (e.g., needle and syringe programs, health clinics, etc.) are located.

(7) The penalties applied by the Commission shall not include custodial penalties.

(8) If the person apprehended for the offences referred to in Section (1) is found by the Commission to be dependent on a narcotic or psychotropic substance, the Commission may order that the person attend a specified number of meetings with the provider of a drug dependence treatment programme, the purposes of which shall be to ensure the person is aware of the programme's services that may assist in overcoming drug dependence and to determine whether the person wishes to avail himself or herself of the services of the programme. The Commission may not compel the person to undergo drug dependence treatment.

OR:

Option 2: Non-custodial sentencing measures

(1) Notwithstanding the provisions of this or any other statute, where
(a) a person is found guilty in a court of law of the offence of possession of a narcotic or psychotropic substance contrary to the law;
(b) in the court's opinion, taking into account the quantity of the substance possessed and all other relevant circumstances of the case, the use or possession of a narcotic or psychotropic substance was for the purpose of personal use; and
(c) the applicable sentence would ordinarily include a custodial sentence;

a court shall, rather than imposing a custodial sentence, order one or more of the following:
(a) direct that the person be discharged absolutely or on the conditions prescribed in a probation order;
(b) suspend the passing of sentence and direct that the person be released on the conditions prescribed in a probation order;
(c) fine the person, if the court is satisfied that the person is able to pay the fine;
(d) order that the person serve the sentence through community service, subject to the person's complying with the conditions of a conditional sentence order; or
(e) make a supervised attendance order with the consent of the person requiring him or her to attend a place of supervision for such time as is specified in the order and, during that time, to carry out such instructions as may be given to him by the supervising officer within the lawful exercise of that officer's authority.

(2) As a term of a probation order or a conditional sentence order in Section (1), the court may order that the person attend a specified number of meetings with the provider of a drug dependence treatment programme, the purposes of which shall be to ensure the person is aware of the programme's services that may assist in overcoming drug dependence and to determine whether the person wishes to avail himself or herself of the services of the programme. The court may not compel the person to undergo drug dependence treatment.

(3) The court may make an order as described in Section (1) if the court considers it to be in the best interests of the accused and not contrary to the public interest, having regard to the age and character of the offender, the nature of the offence and the circumstances surrounding its commission. In making such a determination, the court shall consider the results of any clinical assessment that may have been made of the person.

Recommendation 6: Ensure policing practices do not undermine health services to reduce harms associated with drug use

While various offences related to drugs remain in place, the way in which such laws are enforced can have a significant impact in helping or hindering public health, including measures to prevent HIV among drug users. Hence the importance of the recommendation (Recommendation 2 above) that there be a clear direction, including even in legislation, that harm reduction is a key element of the national strategies

on HIV and on drugs, and that bodies responsible for enforcing drug laws are to cooperate with health authorities in seeing such measures succeed. For a specific example, consider that police patrols around drugstores and the sites of harm reduction programmes can serve to deter people from seeking those services (e.g., to get sterile syringes) and thereby undermines public health by contributing to the risks of HIV and other harms from drug use. It is recommended that instructions to and training for law enforcement bodies and personnel explicitly instruct police not to patrol closely such facilities.

Recommendation 7: Preclude criminal or administrative liability for harm reduction programmes

In order to ensure they are most effective in advancing their mandate of protecting and promoting health, the harm reduction and outreach activities of non-governmental organizations targeting people who use drugs, such as programmes providing sterile syringes or other equipment to reduce harms associated with drug use (including HIV transmission), should be clearly exempt from possible legal liability.

To this end, the national expert group recommends a legislative amendment to add the following text to Article 296 of the *Criminal Code* (specifically in relation to the offence of "inducing consumption"):

> The present article does not apply to cases of distributing information aimed at preventing infection with HIV or other infectious diseases among people who use narcotic or psychotropic substances or the distribution of corresponding tools and equipment for this purpose.

It is suggested that this recommendation should also extend to other aspects of the law which create a similar risk of legal liability, which should be addressed in a similar fashion. In particular, harm reduction programmes also should be clearly exempt from liability for "propagation of narcotics" under the *Law on narcotics* (Article 47) and exempt from liability for the offence of "organizing or maintaining sites" for the consumption of such substances (*Criminal Code*, Article 297). Wording such as the proposal above from the national expert group could easily be added to these other existing provisions as well, to achieve the same effect.

Recommendation 8: Avoid confiscation of equipment distributed by harm reduction programmes

The national expert group also expressed specific concern about ensuring that harm reduction programmes not be undermined by law enforcement personnel confiscating from people who use drugs the information and materials they receive from these programmes, such as syringes. To this end, the group recommends that Article 45 of the *Law on narcotics* (which provides for confiscation of equipment used for consuming drugs) be amended to make it clear that this does not cover sterile injection equipment and other items provided by harm reduction programmes (including those run by NGOs) with the objective of preventing HIV infection and other harms. This could be done by adding the following provision to Article 45:

> The present article does not authorize confiscation of items distributed by harm reduction programmes with the objective of preventing infection with HIV or other infectious diseases among people who use narcotic or psychotropic substances.

Recommendation 9: Eliminate penalty for possession of *used* drug equipment

If someone stopped by police can face criminal or administrative liability for possessing drug equipment after it has been used, based on residual amounts of the drug found in or on the equipment, then this makes it less likely that people will dispose safely of such equipment after using drugs. This means they will be less likely to return used equipment to health services such as needle and syringe programmes where they can obtain new, sterile equipment. Disposing quickly of such equipment also means that a person with no equipment in hand is likely to be at greater risk of sharing someone else's equipment in future. The national expert group expressed concern about this potential to undermine the benefit of

needle and syringe programmes, and has recommended legislative amendments to avoid this interference with harm reduction measures. To this end, legislative provisions such as the following should be enacted (perhaps by adding it to the *Law on narcotics*:[1236]

No penalty for possession of residual amounts of substances in drug use equipment

A person who is in possession of any residual amount of a prohibited narcotic or psychotropic substance that is contained in or on a syringe or other equipment used to ingest such a substance does not, by the mere fact of that possession, commit an offence under any law.

Recommendation 10: Limit compulsory drug testing

Currently, even though drug use is not a punishable offence, the law allows compulsory drug testing to detect drug use in various circumstances, even based on a simple suspicion of drug use. The national expert group and the technical advisors have concluded that the current provisions of the *Law on narcotics* that provide for widespread use of compulsory drug testing encourage people who use drugs "to go clandestine" and avoid health services, including seeking medical assistance in circumstances where overdose occurs. By contributing to the further marginalization of drug users from health services, such measures contribute to their risk of HIV infection and the spread of HIV. As outlined above, such provisions infringe numerous human rights. Among other things, compulsory drug testing violates privacy and security of the person, without justification in most circumstances, since merely showing past use of drugs does not prove there is a risk of harm to self or others, which should be the only basis for possibly justifying an intrusion by the state into such rights.

It is therefore recommended to introduce changes to Article 50 of the *Law on narcotics* to limit the application of compulsory drug testing. The law should at least be amended to limit compulsory testing to only those circumstances in which a person has committed an illegal act. To this end, the national expert group has suggested striking out paragraphs 1-2 of Article 50 of the *Law on narcotics* and substituting the following wording:

Compulsory medical examination on drugs (testing) is prohibited, unless by police in case of suspicion that a person has committed an illegal act; or by court order in circumstances provided by the law.

However, the government should also consider going further, by eliminating any use of compulsory drug testing linked to criminal or administrative offence. Instead, as suggested above, such invasion of people's bodies and privacy should be limited to only those circumstances in which there is a clear, defensible assessment that the person is at imminent risk of harming himself/herself or others.

Drug dependence treatment

Recommendation 11: Introduce opioid substitution therapy as one element of a comprehensive approach to drug dependence treatment

The national expert group has noted that currently opioid substitution treatment (OST) is not available as a treatment method for people with drug dependence, either in the community at large or for prisoners, but that the possibility of introducing a pilot project (outside prison) is under discussion. The national expert group and the technical advisors recommend that OST be introduced in Turkmenistan as one option for treatment, with legislative amendments to the *Law on narcotics* should these prove necessary. To achieve this, a provision such as the following should be added:

Opioid substitution as a component of drug dependence treatment

As one important element of protecting and promoting the health of people who use prohibited substances, including reducing the risks of HIV transmission associated with drug injecting, the Ministry of Health and Medical Industry is responsible for ensuring access to medications for opioid substitution treatment, as one aspect of treatment for those with dependence on opioids.

It is also recommended that medications such as methadone and buprenorphine be registered for prescription in Turkmenistan and added to the national list of essential medicines.

Recommendation 12: Improve access to voluntary treatment

The national expert group has recognized that notwithstanding general statements in the law about protecting confidentiality of patients' health information, there are infringements of said confidentiality. Concern about loss of confidentiality, including providing information to law enforcement that can result in prosecution for administrative or criminal offences, is an obvious disincentive to seeking treatment. The national expert group recommends that the government organize and support a network of sites providing greater access to drug dependence treatment that is voluntary, free and anonymous.

Recommendation 13: Revisit operation of drug user registry, protect confidentiality

Currently, for people receiving drug dependence treatment, there are unjustifiably broad exceptions to the general requirement of maintaining medical confidentiality of patients — including disclosure of patient information to law enforcement bodies upon request, and an obligation to report cases of overdose and those seeking treatment for drug dependence to law enforcement bodies. The national expert group and the project technical advisors observe that the current system of registration of drug users is one factor that discourages people from seeking medical treatment, including for drug dependence, and provides a basis for various infringements of confidentiality. It is therefore recommended that the government begin an assessment of the efficacy and cost-effectiveness of the current approach. This should be included in a consultation process about reforming Turkmenistan's drug policy and practices with a view to reforming the system to ensure it is effective in protecting and promoting health and in respecting and protecting human rights. To protect confidentiality better, legislative provisions such as the following could be added to the *Law on narcotics* and/or the *Law on health protection of citizens*:

Confidentiality of patients' information

(1) The confidentiality of all health care information shall be respected. Records of the identity, diagnosis, prognosis or treatment of any patient which are created or obtained in the course of drug dependence treatment:
(a) are confidential;
(b) are not open to public inspection or disclosure;
(c) shall not be shared with other individuals or agencies without the consent of the person to whom the record relates; and
(d) shall not be discoverable or admissible during legal proceedings.

(2) No record referred to in Section (1) may be used to
(a) initiate or substantiate any criminal charges against a patient; or
(b) act as grounds for conducting any investigation of a patient.

Recommendation 14: Address overdose among people who use drugs

First, it is recommended to repeal the Order of the Ministry of Health and Medical Industry No.300 (14 October 2000) which provides for notification by medical workers of law-enforcement bodies if there is suspicion of poisoning with drugs. The legislation should contain prohibition of violation of patients' privacy and provide for legal liability in case of confidentiality is violated; there may be some exceptional, narrow circumstances in which breaching confidentiality may be justified and these should be clearly set out in the law as limited exceptions.

1236 See *Legislating for Health and Human Rights: Model Law on Drug Use and HIV/AIDS*, Module 3: Sterile syringe programs, pp. 19-21.

Second, the national expert group has recommended that medical personnel (including prison staff) receive training in diagnosing and providing emergency treatment for overdose.

Third, it is recommended that naloxone, which can be used to reverse opioid overdoses (that might otherwise be fatal), be registered for use in Turkmenistan. It should be made available for use by health care workers, who should also receive training on its use. Consideration should also be given to making naloxone, and information on its use to reverse overdoses, available to outreach workers from harm reduction programmes and to people who use opioids or whose acquaintances are at risk of overdose. It is also recommended to allow peer educators among prisoners and prison staff to administer naloxone in case of overdose in penitentiary institutions, and train them to use this emergency response medication.

Recommendation 15: Ensure women's access to voluntary drug dependence treatment

Currently, the national programme against drugs contains a proposal to open a hospital for compulsory drug dependence treatment for women. The national expert group and the project technical advisors have recommended replacing this paragraph in the programme with a commitment "to improve the provision of assistance to women with drug dependence by expanding the network of anonymous, free, *voluntary* services for counselling and drug dependence treatment and including facilities specifically intended to provide services to women."

Recommendation 16: Limit the use of compulsory treatment (drug dependence and HIV and other)

Under current Turkmen law, compulsory treatment may be imposed in a wide range of circumstances, including on:

- any person with HIV (because it is designated as a "dangerous infectious disease");[1237]
- anyone with drug dependence who evades medical treatment and continues to use narcotics;[1238] and
- any prisoner.

But international organizations underline the principle that drug dependence treatment should generally be voluntary.[1239] As a general proposition, compulsory medical treatment violates human rights, including to liberty, security of the person and privacy,[1240] and should be applied only in extreme, clearly defined cases with a view to preventing a person from causing imminent serious harm to himself/herself or to others. It is recommended that the Ministry of Health and Medical Industry review the efficacy and costs of current approaches to compulsory drug treatment, the experience of other jurisdictions (including protections to ensure that compulsory treatment is limited to exceptional circumstances), and bring forward a number of legislative amendments.

First, the government should amend the law to remove HIV from the list of "dangerous infectious diseases" that automatically subject any person living with HIV to the possibility of compulsory treatment.

Second, the government should consider enacting legislation such as the following to ensure treatment is done in accord with good practice and human rights norms:

Basic rights of patients

Every patient has the right:

1237 *Law on health protection of citizens*, Article 28.

1238 *Law on narcotics*, Article 42; *Criminal Code*, Article 94..

1239 UNODC and WHO, *Principles of Drug Dependence Treatment, Discussion paper*, March 2008, page 9.

1240 *International Covenant on Civil and Political Rights*, 999 U.N.T.S. 171 (1966), Articles 7, 9 and 17; *Universal Declaration of Human Rights*, UN General Assembly Resolution 217A (III), UN Doc. A/810 (1948), Articles 3 and 12.

(a) to a full course of high-quality treatment and follow-up support to be provided in accordance with good clinical practice;
(b) to treatment without discrimination;
(c) to meaningful participation in determining his or her own treatment goals, which may include but are not limited to abstinence or changes in drug use that minimize the harms of dependence;
(d) to meaningful participation in all treatment decisions, including when and how treatment is initiated and withdrawal from treatment;
(e) to exercise his or her rights as a patient, including:
(i) reporting, without retribution, any instances of suspected abuse, neglect, or exploitation of patients in the programme;
(ii) a grievance and appeal process, in accordance with national laws and regulations;
(iii) input into the policies and services of drug dependence treatment programmes; and
(iv) voluntary withdrawal from treatment at any time.

(f) to confidentiality of medical records and clinical test results; and
(g) to be fully informed, including but not limited to the right to receive information on:
(i) his or her state of health;
(ii) his or her rights and obligations as a patient, as specified in this Part and in applicable law;
(iii) the procedure for making a complaint about the services received through the programme; and
(iv) cost and payment conditions and the availability of medical insurance and other possible subsidies.

Informed consent

(1) Informed voluntary consent of a patient is a necessary preliminary condition for medical treatment or a preventive or diagnostic intervention.

(2) The following are the elements required for consent to treatment:
(a) the consent must relate specifically to the treatment administered;
(b) the consent must be fully informed;
(c) the consent must be given voluntarily;
(d) the consent must be provided in writing; and
(e) the consent must not be obtained through misrepresentation or fraud.

(3) A consent to treatment is fully informed if, before giving it:
(a) the person received the information about the matters set out in Section (4) that a reasonable person in the same circumstances would require in order to make a decision about the treatment; and
(b) the person received responses to his or her requests for additional information about those matters.

(4) The matters referred to in Section (3) are:
1. The nature of the treatment.
2. The expected benefits of the treatment.
3. The material risks of the treatment.
4. The material side effects of the treatment.
5. Alternative courses of action.
6. The likely consequences of not having the treatment.

Withdrawal from treatment

(1) A patient shall have the right to withdraw voluntarily from treatment at any time.

(2) The health practitioner shall fully inform the patient of the potential risks and benefits of withdrawal from treatment and shall work with the patient to ensure the patient's safety and comfort during the withdrawal process.

(3) The health practitioner shall not discontinue services that are needed unless the patient requests the discontinuation, alternate services are arranged, or the patient is given a reasonable opportunity to arrange alternate services.
(4) The withdrawal from treatment with an explanation of likely consequences shall be recorded or registered in medical documentation and signed by the patient and health practitioner.

(5) Involuntary withdrawal from treatment shall be avoided except where compelling reasons exist. Regulations governing grounds for involuntary withdrawal shall be clearly communicated to patients at the outset of treatment.

HIV prevention and treatment

Recommendation 17: Strengthen legal framework for harm reduction measures to prevent HIV among vulnerable populations

While official statistics indicate very low HIV prevalence currently in Turkmenistan, HIV risk behaviours are well documented, meaning it is important to take proactive steps now to prevent HIV from becoming more widespread, particularly among groups at elevated risk. To this end, the government should strengthen the existing *Law on prevention of HIV* by legislatively mandating measures to reduce harms, including HIV infection, particularly among people who use drugs and people who use drugs and people in prison or in detention facilities. This should include high-level directives specifically to government bodies and agencies such as the Ministry of Health and Medical Industry (which is responsible for health generally) and the Ministry of Internal Affairs (which has responsibility for ensuring the health of prisoners), to take the primary lead on ensuring such measures are implemented. Directives should also issue that clearly direct law enforcement bodies (including the State Coordination Commission on the Fight Against Narcotic Addiction) to cooperate with other government bodies and with non-governmental organizations to ensure the effective delivery and operation of harm reduction services (e.g., sterile syringe programmes, OST). The numerous other specific legislative amendments proposed in this report are aimed at creating such a supportive legal framework.

But it would also be advisable to have a clear, overarching statement in both the *Law on prevention of HIV* and the *Law on narcotics* clearly articulating this objective, and that harm reduction programmes and services are an important element of pursuing this objective. A legislative provision such as the following should be added to these two statutes:

Harm reduction an essential element in national health and drug policy

(1) Preventing and reducing the spread of HIV, other blood-borne and sexually transmitted infections, and other harms is a key objective of national health policy and national policy on illicit drugs. Health services and programmes, operated and delivered by both public authorities and non-governmental organizations with these objectives, are necessary and important elements of implementing such policy, particularly in addressing these individual and public health concerns among groups that face an elevated risk of such harms, including but not limited to people who use narcotics and psychotropic substances and people in prisons or other places of detention.

(2) Public authorities responsible for health, including the health of these groups, will act to implement such services described in section (1), based on the best available evidence of need and efficacy and in accordance with human rights obligations. Other public authorities, including those responsible for enforcement of laws on narcotics and psychotropic substances, will cooperate in pursuing these health objectives.

Recommendation 18: Limit the use of compulsory HIV testing

If HIV testing is ever to be imposed without consent, then it requires a process clearly set out in law, with a requirement that such measures be taken only in exceptional circumstances and with adequate justification that must be considered by an independent, judicial body, and with the most limited infringement of human rights possible.[1241]

- However, the national programme against AIDS currently calls for obligatory HIV testing of people with drug dependence and of pregnant women. Such testing unjustifiably infringes human rights to security of the person, privacy, and equality. It is recommended to remove this direction from the national programme against AIDS.

- In addition, the *Law on prevention of HIV* currently provides for obligatory HIV testing for a wide range of people, including people who use drugs and who are receiving drug dependence treatment, people with other diagnosed STIs or with TB, prisoners, sex workers, foreign citizens staying in Turkmenistan longer than three months, pregnant women, and a large number of health workers.[1242] This widespread use of obligatory HIV testing is not a good use of resources and also infringes human rights norms for many people. In accordance with international standards, it is recommended to amend the *Law on prevention of HIV* to clearly prohibit obligatory HIV testing except in the case of donors of blood, organs or other bodily tissues or substances. Adding a legislative provision such as the following would be advisable:

Voluntariness of HIV testing

(1) Every person is entitled to free confidential [or anonymous] testing for infection with HIV, other blood-borne infections or other sexually transmitted infections, and to counselling in connection with such testing.

(2) No test for HIV, other blood-borne infection or other sexually transmitted infection shall be undertaken except with the informed voluntary consent in writing of the person being tested.

(3) All persons presenting themselves for testing shall be offered pre-test and post-test counselling by a health practitioners, in accordance with professional standards.

Recommendation 19: Respect patients' rights (to privacy)

Currently, the law imposes legal liability on a person diagnosed with an STI (presumably including HIV) for not identifying past sexual contacts (*Code of Administrative Offences*, Article 46). It is difficult to see how this could be effectively enforced in any verifiable way; given this, and that it invades patients' rights to privacy with a significant penalty, this aspect of the law should be reformed, by repealing Article 46 of the *Code of Administrative Offences*.

Recommendation 20: Respect patients' rights (to security of the person)

Currently, the law makes a person potentially administratively or criminally liable for "evading" testing for "venereal diseases" and for "evading" treatment if diagnosed with a STI [presumably including HIV] (Criminal *Code*, Articles 117-118; *Administrative Code* Article 46). The *Law on health protection of citizens* also provides for treatment without a patient's consent in the case of "diseases representing a danger to others", which has been defined to include HIV.[1243] However, except in very limited circumstances, involuntary medical treatment is not consistent with human rights, which require that a patient give informed, fully voluntary consent to treatment. It is recommended that these provisions be repealed.

Recommendation 21: Ensure access to treatment for people living with HIV

According to the *Law on prevention of HIV* (Article 10), people with HIV receiving out-patient treatment are entitled to free medications, including antiretroviral (ARV) therapies. However, as of this writing in December 2008, ARV therapy is not available in Turkmenistan, according to the national expert group. The Ministry

1241 Guidelines such as the UN's *Siracusa Principles* on permissible limitations on human rights should be complied with in any legislative provision that would allow involuntary testing or treatment: UN Economic and Social Council, *Siracusa Principles on the Limitation and Derogation Provisions in the International Covenant on Civil and Political Rights*, UN Doc. E/CN.4/1985/4, Annex (1985).

1242 *Law on prevention of HIV,* Article 11.

1243 It should be noted, however, that ARV treatment is reportedly not available in Turkmenistan, so it is difficult to see how such treatment could be enforced upon anyone at this time.

of Health and Medical Industry should move immediately to ensure that all necessary legal steps have been taken to prescribe ARVs to patients (e.g., registering such medicines for use in Turkmenistan) and that such medications are available for prescription, with the consent of the patient, when clinically recommended. It is also recommended to include ARV medication in the National List of Essential Medicines.

Prisons

Recommendation 22: Create legislative framework to address health needs in prisons, including for people with HIV and with drug dependence

The national expert group has observed that the current penal legislation of Turkmenistan, including the *Corrective Labour Code*, does not include provisions ensuring access to care for persons with HIV and narcotic addiction in correctional institutions, nor the introduction of harm reduction programmes or pre- and post-release programmes for rehabilitation of those with drug dependence. The national expert group has recommended enacting a set of clear legislative provisions that address these issues and that mandate the implementation of such health measures by the Ministry of Internal Affairs and the Ministry of Health and Medical Industry. This will likely necessary changes to the "Internal regulations of penitentiary institutions" regarding prisoners' rights to obtain and possess HIV prevention materials.

In particular, the national expert group has recommended specific attention to the following concerns:

- ensuring access to information materials and training for prisoners and prison personnel on HIV, STIs, and other health issues;
- introducing harm reduction measures for prisoners, including access to opioids substitution therapy and distribution of sterile syringes;
- ensuring access to condoms and disinfectants (e.g., bleach) for prisoners (while also abolition the prohibition on consensual sexual activity between adults of the same sex); and
- training prison personnel in required information and recommendations for prisoners before release.

To this end, legislative provisions such as the following should be enacted (e.g., in the *Corrective Labour Code*):[1244]

Article 1. Purpose of this Part [of the Code]

The purpose of this Part [of the Code] is to contribute to a safe and healthy environment for prisoners and prison staff by:

(a) providing prisoners with humane treatment and support for HIV/AIDS and other blood borne diseases, and for drug dependence, in an environment free of discrimination;
(b) enabling a wide range of services for prisoners to minimize the harms related to unsafe drug use, including the risk of infection by HIV and other blood-borne diseases;
(c) developing a safer work environment for prison staff; and
(d) providing for the development of national data and research on the prevalence of sexual violence (including rape) in prison and the issuance of national standards to eradicate sexual violence in prison.

Article 2. Definitions

For the purposes of this Part, the following definitions are used:

"Cruel, inhuman or degrading treatment or punishment" means any harsh or neglectful treatment that could damage a person's physical or mental health, or any punishment intended to cause physical or mental pain or suffering, or to humiliate or degrade the person concerned.

"Dispensing machine" means any machine or mechanical device used for selling or supplying sterile syringes without the personal attention of the seller or supplier at the time of the sale or supply.

"Drug dependence treatment" means a programme with specific medical or psycho-social techniques aimed at managing or reducing a patient's dependence on one or more controlled substances, thereby improving the general health of the patient. Such programmes include opioid substitution treatment, residential or out-patient services, administration of medicines to reduce cravings or diminish an adverse impact of using controlled substances, psychiatric and psychosocial support services and supervised support groups.

"Health care" refers to services provided by health professionals in the formal health system for prevention or treatment of mental or physical diseases or conditions.

"Health practitioner" means a person entitled under the [relevant health law] to provide health services. Health practitioners include accredited physicians, registered nurses and other trained medical staff.

"Opioid substitution treatment" means the administration of an opioid substitute to a person with dependence on a pharmacologically related opioid, for achieving defined treatment aims, including maintenance treatment.

"Parole" means the authority granted to a prisoner by the [relevant authority] to be in the general community during the prisoner's sentence, and may include day parole.

"Prison" includes

(a) a facility of any description that is operated, permanently or temporarily, by the Ministry of Internal Affairs for the care and custody of prisoners; and
(b) a private prison facility constructed or operated under an agreement with the relevant prison authority for the confinement of prisoners.

"Prisoner" includes

(a) a person who is in a prison pursuant to a sentence for an offence; or who has been convicted of an offence and is awaiting imposition of a sentence; or who is in prison because of a condition imposed by the [relevant authority] in connection with parole or statutory release;
(b) a person who, having been sentenced, committed or transferred to prison, is temporarily outside prison by reason of a temporary absence or work release authorized under [relevant legislation]; or is temporarily outside prison for reasons other than a temporary absence, work release, parole or statutory release, but is under the direction or supervision of a staff member or of a person authorized by the [relevant authority]; and
(c) a person who is in prison awaiting trial.

"Staff", in the context of a sterile syringe programme, includes the following persons:

(a) the operator or manager of the programme;
(b) a person engaged by the operator or manager of the programme to provide services at the facility, whether under a contract of employment or otherwise; and
(c) a person engaged by the operator or manager of the programme to provide voluntary assistance at the facility.

"Sexual violence" means an act of sexual violence, including rape, committed against a prisoner who is in the actual or constructive control of prison officials.

1244 See *Legislating for Health and Human Rights: Model Law on Drug Use and HIV/AIDS*, Module 5: Prisons, pp. 11-36.

"Sterile syringe programme" means a programme that provides access to sterile syringes and other related material, information on HIV transmission and other blood-borne pathogens, or referrals to substance abuse treatment services. It includes needle exchange programmes, needle distribution programmes and other forms of sterile syringe distribution.

"Torture" means any act by which severe pain or suffering, whether physical or mental, is intentionally inflicted on a person for such purposes as obtaining from the person or a third person information or a confession; punishing the person for an act he or she or a third person has committed or is suspected of having committed; or intimidating or coercing the person or a third person; or for any reason based on discrimination of any kind, when such pain or suffering is inflicted by, at the instigation of, or with the consent or acquiescence of, a public official or other person acting in an official capacity. It does not include pain or suffering arising only from, inherent in, or incidental to, lawful sanctions.

Article 3. Human rights governing the procedure and conditions of imprisonment

(1) The state shall respect and protect the human rights and fundamental freedoms of prisoners and shall provide the conditions necessary for their social, legal and medical protection and care.

(2) Except for those limitations that are demonstrably necessitated by the fact of imprisonment, all prisoners shall retain the human rights and fundamental freedoms set out in international human rights law.

Article 4. Rights upon arrest or detention

(1) Anyone arrested or detained on a criminal charge shall be brought promptly before a judge or other officer authorized by law to exercise judicial power and shall be entitled to trial within a reasonable time and without undue delay or to release.

(2) Pre-trial detention shall be used as a means of last resort in criminal proceedings, with due regard for the investigation of the alleged offence and for the protection of society and the victim.

(3) Pre-trial prisoners and others under detention without sentence are entitled to the same rights as sentenced prisoners, including those rights related to health care.

Article 5. Right to equal and adequate health care for prisoners

(1) A prisoner who has tested positive for infection with HIV is entitled to adequate health care, counselling and referrals to support services while in prison.

(2) Health practitioners shall provide prisoners with protection of their physical and mental health and treatment of disease of the same quality and standard as is afforded to those who are not imprisoned or detained.

Article 6. Voluntary counselling and testing

(1) A prisoner is entitled to free confidential testing for infection with HIV and other blood-borne viruses, and to counselling in connection with such testing.

(2) No test for HIV or other blood-borne disease shall be undertaken except with the informed voluntary consent in writing of the prisoner.

(3) All prisoners presenting themselves for testing shall be offered pre-test and post-test counselling by a health practitioner, in accordance with professional standards.

Article 7. Informed consent

(1) Informed voluntary consent of a prisoner is a necessary preliminary condition for medical treatment or a preventative or diagnostic intervention.

(2) The following are the elements required for consent to treatment:

(a) the consent must relate specifically to the treatment administered;
(b) the consent must be fully informed;
(c) the consent must be given voluntarily;
(d) the consent must be provided in writing; and
(e) the consent must not be obtained through misrepresentation or fraud.

(3) For the purpose of paragraph (2)(b), a prisoner's consent to a health care intervention or procedure is informed consent only if the prisoner has been advised of, and has the capacity to understand:

(a) the likelihood and degree of improvement, remission, control or cure as a result of the intervention;
(b) any significant health or other risk, and the degree thereof, associated with the intervention;
(c) any reasonable alternatives to the intervention;
(d) the likely effects of refusing the intervention; and
(e) the prisoner's right to refuse the intervention or withdraw from the intervention at any time.

(4) The prisoner has the right to refuse health care interventions or withdraw from health care interventions at any time. If the prisoner refuses to consent to a specific intervention or procedure, no punitive action shall be taken and medically appropriate alternative interventions or procedures shall, if possible, be made available.

Article 8. Confidentiality

(1) All information on the health status and health care of a prisoner is confidential, and all health care procedures shall be designed so as to preserve the confidentiality of prisoners.

(2) Information referred to in Section (1) shall be recorded in files available only to health practitioners and not to non-health care prison staff. No mark, label, stamp or other visible sign shall be placed on prisoner's files, cells or papers that could indicate his or her HIV status, other than necessary notations inside the medical file in accordance with standard professional practice for recording clinically relevant information about a patient.

(3) Information referred to in Section (1) may only be disclosed:

(a) with the prisoner's consent; or
(b) where warranted to ensure the safety of other prisoners or staff;

with the same principles as generally applied in the community applying to the disclosure.

Article 9. Prohibition of torture and other cruel, inhuman or degrading treatment or punishment

Every health practitioner, or every person acting at the instigation of or with the consent or acquiescence of an health practitioner, who inflicts torture or cruel, inhuman or degrading treatment or punishment on any other person is guilty of an offence [under the Criminal Code] and liable to imprisonment for a term not exceeding [x].

Article 10. No discrimination against prisoners on the basis of HIV or HCV status

(1) In all prison facilities, it shall be illegal to discriminate against a prisoner on the basis of his or her infection with HIV or diagnosis of AIDS, or his or her infection with hepatitis C.

(2) Prisoners living with HIV/AIDS or HCV shall:

(a) be housed with the general prisoner population, unless they require a level of health care which cannot be provided in such a setting or unless separate housing is necessary for their protection from other prisoners;

(b) be offered the same opportunities as other prisoners to participate in educational, job, vocational or other programmes, except where limitations to a specific assignment are clinically indicated; and

(c) have access to the full range of available institutional counselling and support services and, to the greatest extent possible, to local community counselling and support services.

Article 11. **Review of prison policies and practices regarding HIV/AIDS, other blood-borne diseases and drug dependence treatment**

(1) The Ministry of Health and Medical Industry is hereby authorized and directed to review any policy or practice instituted in facilities operated by the Ministry of Internal Affairs regarding HIV/AIDS, other blood-borne diseases and drug dependence, including the prevention of the transmission of HIV and other blood-borne diseases and the treatment of prisoners living with HIV/AIDS, other blood-borne diseases or drug dependence.

(2) Such review shall be performed annually and shall focus on whether such policy or practice is consistent with current, generally accepted medical standards and procedures used in the general population to prevent the transmission of HIV and other blood-borne diseases and to treat persons living with HIV/AIDS, other blood-borne diseases or drug dependence.

(3) Upon the completion of such review, the Ministry of Health and Medical Industry shall, in writing, report to the Ministry of Internal Affairs on such policy or practice as instituted in facilities operated by the latter. The report may direct the Ministry of Internal Affairs to prepare and implement a corrective plan to address deficiencies in areas where such policy or practice fails to conform to current, generally accepted medical standards and procedures. The Ministry of Health and Medical Industry shall monitor the implementation of such corrective plans and shall conduct such further reviews as it deems necessary to ensure that identified deficiencies in policies and practices regarding HIV/AIDS, other blood-borne diseases and drug dependence are corrected.

(4) All written reports pertaining to such reviews provided for in this section shall be maintained as public information available for public inspection.

Article 12. Distribution and possession of condoms and other safer sex materials in prisons

(1) The Ministry of Health and Medical Industry, with the cooperation of the Ministry of Internal Affairs, shall ensure that condoms and other safer sex materials, such as water-based lubricants and dental dams, along with appropriate information on their proper use and on their importance in preventing the spread of HIV infection and other sexually transmitted infections, are made available and easily accessible to prisoners in a manner that protects their anonymity.

(2) The Ministries shall develop a plan for the disposal of used condoms that protects the anonymity of prisoners and the health of prison officers.

(3) The distribution and possession of condoms and other safer sex materials in prisons in accordance with this Part shall not constitute a criminal nor administrative offence, nor are condoms and other safer sex materials admissible as evidence of sexual relations for the purposes of determining any criminal or administrative offence.

Article 13. **Authorization of sterile syringe programmes**

(1) Sterile syringe programmes shall be implemented in all prisons according to the provisions set out herein, with the objective of reducing harms associated with unsafe use of drugs, including the risk of transmission of HIV or other blood-borne diseases.

(2) The Ministry of Health and Medical Industry may authorize a specified person or organization to supply:

(a) sterile syringes and other related material to prisoners; and
(b) information concerning hygienic practices in the use of syringes and other related material;

in order to prevent the spread of blood-borne diseases and minimize the health risks associated with injection drug use by prisoners.

Article 14. Supply of sterile syringes and other related materials

Staff of a sterile syringe programme may provide the following material:
(a) sterile syringes and other related material for safer injection drug use, including sterile water ampoules, swabs, filters, safe acid preparations, spoons and bowls and other appropriate materials;
(b) material to enable safer smoking and inhalation of drugs, such as pipes, stems, metal screens, alcohol wipes and lip balm; and
(c) condoms and other safer sex materials such as water-based lubricants and dental dams, as well as information about reducing the risks of HIV and other sexually transmitted infections.

Article 15. Information

Staff of sterile syringe programmes may provide information including, but not limited to, the following:

(a) drug dependence treatment services and other health services;
(b) means of protection against transmissible diseases, including blood-borne diseases such as HIV;
(c) the risks associated with the use of controlled substances;
(d) harm reduction information specific to the drug being used, including safe injecting and inhaling practices;
(e) legal aid services;
(f) employment and vocational training services and centres; and
(g) available support services for people with drug dependence and their families.

Article 16. Distribution and possession of sterile syringes and related material

(1) An authorized person or organization may distribute sterile syringes and related material via one or more of the following means:

(a) prison nurses or physicians based in a medical unit or other area(s) of the prison;
(b) prisoners trained as peer outreach workers;
(c) non-governmental organizations or health professionals who enter the prison for this purpose;
(d) one-for-one automated sterile syringe-dispensing machines.

(2) Wherever possible, sterile syringes and related material shall be made available to prisoners without the necessity of the prisoner identifying himself or herself to prison authorities.

(3) The Ministry of Internal Affairs shall establish rules for the safe storage of syringes possessed by prisoners in accordance with the provisions of this Part.

(4) The sterile syringe programme shall include measures to encourage safe disposal of syringes and monitor the number of syringes distributed and the number in storage.

(5) Sterile syringes and related material distributed pursuant to this Part shall be used only in accordance with this Part and any other applicable Regulations or institutional policies established pursuant to this Part.

(6) The distribution and possession of syringes and related material in prison in accordance with this Part shall not constitute a criminal nor administrative offence, nor shall such items be admissible as evidence of illegal drug use for the purposes of determining any criminal or administrative offence.

Article 17. Availability of bleach as a disinfectant

(1) Bleach and instructions on using bleach as a disinfectant shall be made available in accordance with this Part and any other applicable Regulations or institutional policies established pursuant to this Part.

(2) Any such Regulations or policies established pursuant to Section (1) will:

(a) encourage participation of prisoners and their assistance in bleach distribution;
(b) ensure that bleach is available to prisoners in ways that preserve prisoners' anonymity; and
(c) ensure that in no instance shall a prisoner be required to approach a staff member in order to obtain bleach.

(3) Bleach distributed pursuant to this Part shall be used only in accordance with this Part and any other applicable Regulations or institutional policies established pursuant to this Part.

(4) The distribution and possession of bleach in prison in accordance with this Part shall not constitute a criminal nor administrative offence, nor shall such items be admissible as evidence of illegal drug use for the purposes of determining any criminal or administrative offence.

Article 18. Opioid substitution treatment programmes in prison

(1) The Ministry of Health and Medical Industry, with the cooperation of the Ministry of Internal Affairs, shall establish opioid substitution treatment programmes in all prisons.

(2) Prisoners with opioid dependence shall be eligible for opioid substitution treatment in accordance with opioid substitution treatment guidelines applicable in the community.

(3) Opioid substitution treatment shall be available for free on imprisonment and throughout the duration of imprisonment.

(4) Opioid substitution treatment shall not be restricted to those on a course of opioid substitution treatment prior to imprisonment; all prisoners shall be entitled, if eligible, to being on opioid substitution treatment while incarcerated.

(5) Participation in the opioid substitution treatment programmes shall be offered on a voluntary basis to all prisoners with opioid dependence.
(6) Opioid substitution treatment programmes may include a variety of approaches, including maintenance treatment.

(7) The programme shall ensure that staff members, prison officers, policy makers and prisoners have factual information regarding opioid substitution treatment.

(8) The programme shall develop a comprehensive discharge planning system for prisoners nearing release, including a system for referral to opioid substitution treatment programmes in the general community.

Article 19. Information and education programmes regarding HIV/AIDS, other blood-borne diseases and drug dependence treatment in prisons

(1) The Ministry of Health and Medical Industry shall develop and implement information and education programmes in every prison to help prevent the spread of HIV, other blood-borne diseases, and to address drug dependence among prisoners.

(2) In developing such programmes, the Ministry shall use materials that are likely to be effective in reducing transmission of blood-borne diseases within prisons and outside prison following the release of prisoners, as well as providing information on treatment, care and support.

(3) Such programmes required by Section (1) may include peer education and use of non-Ministry personnel, including delivery of these programmes by community-based organizations.

(4) Materials shall, as much as possible, be available in the languages of the relevant populations, shall take into account the literacy level of the relevant populations, and shall be sensitive to the social and cultural needs of the relevant populations.

Article 20. Responsibility for providing training and education

The Ministry of Health and Medical Industry is responsible for ensuring, with the cooperation of the Ministry of Internal Affairs:

(a) that training and education are provided to staff and prisoners on a regular basis, and that such training and education include the principles of standard precautions to prevent and control blood borne diseases; the personal responsibility of staff and prisoners to protect themselves and others at all times; and information on post-exposure prophylaxis;
(b) that training and education provided to prisoners also include available services and treatments; and peer education and counselling programmes that include the meaningful participation of prisoners as counsellors; and
(c) that prisoners and staff who may be exposed to blood and body fluids receive training in universal precautions.

Article 21. Statistics on sexual violence (including rape) in prisons

(1) The Ministry of Health and Medical Industry shall carry out, at regular intervals, a comprehensive statistical review and analysis of the incidence of sexual violence in prisons, which shall include, but not be limited to, the identification of the common characteristics of:
(a) both victims and perpetrators of sexual violence; and
(b) prisons and prison systems with a high incidence of said violence.

(2) In carrying out Section (1), the Ministry shall consider:
(a) how incidents of sexual violence will be defined for the purposes of the statistical review and analysis; and
(b) how the Ministry should collect information about sexual violence against prisoners committed by other prisoners and by staff, beyond prisoner self-reports of such violence.
(3) The Ministry shall solicit views from representatives of the following: state prison departments, county and municipal prisons, juvenile prison facilities, former prisoners, health service providers, victim advocates, researchers, and other experts in the area of sexual violence (including within prisons).

Article 22. Development of national standards against sexual violence in prisons

(1) The Prosecutor General, the Ministry of Internal Affairs and the Ministry of Health and Medical Industry shall develop national standards for enhancing the detection, prevention, and reduction of sexual violence (including rape) in prisons and for prosecution of offenders.

(2) The information provided under paragraph (1) shall include national standards relating to:
(a) the classification and assignment of prisoners, using standardized instruments and protocols, in a manner that limits the occurrence of sexual violence in prison;
(b) the investigation and resolution of prisoners' complaints of sexual violence by responsible prison authorities, local and state police, and national and state prosecution authorities;
(c) the preservation of physical and testimonial evidence for use in an investigation of the circumstances relating to sexual violence;
(d) acute trauma care for victims of sexual violence, including standards relating to the manner and extent of physical examination and treatment to be provided; and the manner and extent of any psychological or psychiatric examination and care, medication or counselling to be provided;
(e) referrals for long-term continuity of care for those who have experienced sexual violence;
(f) educational and medical testing measures for reducing the risk of HIV transmission as a result of sexual violence in prison;
(g) post-exposure prophylactic measures, including a short course of antiretroviral drugs, for reducing the incidence of transmission of HIV;
(h) the training of prison staff sufficient to ensure that they appreciate the significance of sexual violence in prison and the need to prevent it;
(i) the timely and comprehensive investigation of staff sexual misconduct involving rape or other sexual violence on prisoners;
(j) creating a system for reporting incidents of sexual violence in prison that will ensure the confidentiality of complainants, protect prisoners who make complaints from retaliation, and assure the impartial resolution of complaints;
(k) data collection and reporting of sexual violence (including rape) in prison, sexual misconduct toward prisoners on the part of prison staff, and the resolution of prisoners' sexual violence complaints by prison officials and national, state, and local investigation and prosecution authorities; and
(l) such other matters as may reasonably be related to the detection, prevention, reduction and punishment of sexual violence in prison.

Recommendation 23: Allow compassionate release from prison based on health concerns

In the current legislation of Turkmenistan there are provisions to ensure early release from penitentiary institutions due to illness. However, HIV and AIDS are not on the list. It is recommended that these be added, as HIV disease is a serious, chronic infection that can progress much more quickly in adverse conditions, including those in penitentiary institutions. To save the life and health of people living with HIV, those with such a diagnosis should be eligible for compassionate release. The *Corrective Labour Code* should be amended by adding a provision such as the following:

Compassionate Release

Conditional or unconditional release may be granted by the Ministry of Internal Affairs, or a court, at any time to a prisoner:
(a) who is terminally ill;
(b) whose physical or mental health is likely to suffer serious adverse effects if the prisoner continues to be held in confinement; or
(c) for whom continued confinement would constitute an excessive hardship that was not reasonably foreseeable at the time the prisoner was sentenced.

Discrimination

Recommendation 24: Strengthen protection against HIV-related discrimination

Discrimination against people based on HIV status is discrimination based on "other status" that goes against basic human rights norms established in international law.[1245] It also undermines efforts to prevent the spread of HIV and ensure care, treatment and support for those who are infected. It is recommended that the Government consult key officials and national and international experts, including people living with HIV and representatives of civil society, to begin implementing reforms to existing programmes and laws that will add or strengthen measures to prohibit, prevent and provide redress for discrimination based on HIV status.

Recommendation 25: Eliminate discriminatory restrictions on travel or residence based on HIV status

Currently, HIV-positive status is a basis on which to deny a visa or residence permit to a non-citizen and to deport non-citizens from Turkmenistan. Such treatment amounts to discrimination that is not justified. It is recommended that the Government amend Article 18 of the *Law on migration* to remove this feature of the law.

Recommendation 26: Eliminate discrimination in employment based on HIV status

Currently, the Constitution has a very broad prohibition on discrimination, and the *Law on prevention of HIV* prohibits unreasonable refusal to employ, or unreasonable dismissal of, people with HIV or AIDS. This is consistent with international human rights law. Yet Turkmen law also currently restricts people from working in certain trades or occupations based on HIV-positive status, which amounts to discrimination that can rarely be justified.[1246] To rectify this inconsistency, and to protect better the rights of people living with HIV, two steps can be taken.

- First, the Government should review existing orders or other official government documents that include HIV on a list of diseases that preclude a person from holding certain positions, and amend them to remove any reference to HIV unless there is a clear, scientifically sound basis establishing that performing such employment cannot be done without posing a significant risk to the health of another person.
- Second, a legislative amendment to the *Law on prevention of HIV* should be added that could be worded as follows:

> Discriminating against a person on the basis of his or her HIV infection or AIDS diagnosis [or on the basis of other blood-borne infection] is prohibited, including but not limited to such contexts as employment [or education]. It is unlawful discrimination to require that a person be tested for HIV as a condition of employment [or enrolment in an educational institution], either before or during employment [or enrolment].

Recommendation 27: Eliminate workplace discrimination against drug-dependent persons

Testing of workers for the presence of drugs is currently carried out under the *Law on narcotics* and pursuant to the "National programme against drug trafficking for the period 2006-2010" (para. 34). However,

1245 International law guarantees equal protection of the law and protection against discrimination: *International Covenant on Civil and Political Rights*, Articles 2 and 26. The UN Commission on Human Rights has determined that the term " other status", as used in the ICCPR and numerous other instruments in international human rights law in prohibiting discrimination, includes "health status", including HIV/AIDS — that is, discrimination on the basis of health status, including on the basis of HIV or AIDS diagnosis, is prohibited. E.g., see UN Commission on Human Rights, Resolutions 1995/44 (3 March 1995), 1996/43 (19 April 1996), and 2004/26 (16 April 2004.).

1246 E.g., see UNAIDS/OHCHR, *International Guidelines on HIV/AIDS and Human Rights*, para. 149. Similar analysis would apply to discrimination against someone based on something like infection with hepatitis B or C virus (HBV, HCV) or on the basis of a sexually transmitted infection. Given modes of transmission, many people who inject drugs are vulnerable to infection with other blood-borne diseases such as HBV or HCV, in addition to HIV, and may face discrimination on that basis, as has been observed in other jurisdictions. In making amendments to strengthen protection against HIV-related discrimination in an area such as employment or educational contexts, it would be advisable to explicitly include protection against discrimination based on such other diseases.

requiring drug testing *before* employment is unjustified discrimination based on health condition. Requiring testing for drug use *during* employment may only be potentially justifiable in quite limited circumstances, such as limiting testing to positions that are safety-sensitive and then only in cases where there are reasonable grounds to suspect impairment or possibly random drug testing of persons returning to work after receiving treatment for drug dependence.

- It is recommended to begin a consultation process with policy-makers and to study experiences of other countries for models of legislation that limits restrictions on permitted occupations based on drug use only in specific cases defined in the law and based on individual assessments of ability to perform.

- Provisions in the *Law on narcotics* and in the national anti-drug programme that encourage or permit workplace drug testing in overly broad circumstances should be eliminated.

- Instead, it is recommended that the law (perhaps the *Law on narcotics*) be amended to include a provision along the lines of the following:[1247]

Discrimination based on drug use

(1) Absent a reasonable justification given the circumstances of the case, it is prohibited to discriminate against a person, or a relative or associate of the person, on the ground that the person uses or has used drugs, or is perceived to use or have used drugs.

(2) It is unlawful discrimination to require that a person undergo drug testing as condition of enrolment in an educational institution, either before or during enrolment.

(3) It is unlawful discrimination to require that a person undergo drug testing as a pre-condition of employment. Making drug testing a condition of continued employment is permitted only in positions, as designated by [suitable government authority], where impairment while at work may pose a significant risk of harm to the individual employee or to others *and* where there are reasonable grounds to suspect that the individual employee may be impaired by drug use.

Recommendation 28: Respect and protect family relationships

As noted above, current law states that in the case of concern about child abuse or neglect, drug or alcohol dependence[1248] can *per se* be a basis for deprivation of parental rights (custody of a child). This risks discriminating against people based on a health condition, rather than ensuring careful regard for individual circumstances; which would not be justified. Thus, Article 70 of the *Code of Marriage and Family* should be amended to clarify clarify that, in cases of concern about child abuse or neglect, drug dependence should not be assumed to be *per se* sufficient grounds to deprive someone of parental rights, but rather than a careful analysis of the individual circumstances is required., governed by the over-riding consideration of the best interests of the child.

Recommendation 29: Eliminate discrimination in voting rights

Currently, prisoners and persons in preventive detention are denied the right to vote under various decrees. International law recognizes that prisoners retain all human rights except those necessarily limited by the fact of incarceration. Denying the right to participate in elections does not meet this test. These prohibitions should be repealed.

1247 See *Legislating for Health and Human Rights: Model Law on Drug Use and HIV/AIDS*, Module 7: Stigma and discrimination, pp. 13-15.

1248 *Code on Marriage and Family of Turkmenistan*, Article 70.

Recommendation 30: Avoid overly broad application of criminal law regarding HIV/STI transmission

It is recommended to repeal Article 117 of the *Criminal Code*, which criminalizes knowing STI transmission, and Article 11 of the *Criminal Code*, which that criminalizes exposure and transmission of "the AIDS disease" ("knowing exposure to AIDS").[1249] Any use of the criminal law to deal with HIV transmission should follow the guidance issued by UNAIDS in applying the law to fairly narrow circumstances.[1250]

Recommendation 31: Abolish legislative discrimination based on sexual orientation

Under current law, consensual sex between adult men remains a crime (*Criminal Code*, Article 135). As noted above, this discrimination contravenes international human rights law, including rights to non-discrimination and privacy, and is counter-productive in that it undermines HIV prevention efforts and access to health information and services among men who have sex with men.[1251] The national expert group has recommended initiating discussions for the purpose of abolishing of the criminal liability for consensual homosexual activity between adults. To achieve this, Article 135 of the *Criminal Code* should be repealed.

Recommendation 32: Enact reforms to protect the health and safety of sex workers

Currently, the law imposes administrative and criminal liability for prostitution and related activities. Such measures do not prevent or eliminate prostitution, but rather contribute to the lack of safety of sex workers and create barriers to protecting and promoting the health of sex workers, including through programmes and services to prevent and treat HIV and other STIs. Violence and abuse of sex workers are critically important human rights issues, and adequately enforcing existing laws against such abuses should be a priority, rather than imposing penalties on sex workers. It is recommended to begin discussions with the objective of abolishing such administrative or criminal liability for prostitution and for a range of related activities. To achieve this objective, the Government should abolish both administrative and criminal law provisions regarding prostitution: Articles 176(1) and 176(2) of the *Administrative Offences Code*, and Article 138 of the *Criminal Code*.

1249 *Criminal Code*, Article 119.

1250 UNAIDS, *Policy Brief: Criminalization of HIV transmission* (August 2008).

1251 International Guidelines on HIV/AIDS and Human Rights, guideline 4, para.21(b); and UNAIDS Policy Brief "*HIV and Sex Between Men*", August 2008.

UZBEKISTAN

SUMMARY REPORT AND RECOMMENDATIONS

UZBEKISTAN: SUMMARY REPORT AND RECOMMENDATIONS

1. BACKGROUND

With a population of more than 27 million people, Uzbekistan is the most densely populated country in Central Asia.[1252] Like other countries of Central Asia, Uzbekistan faces an increasing drug use problem. In 2008, the total number of people using drugs and registered as such for medical surveillance and prevention purposes was an estimated 21,439 people; 85,6% of them were opioid injectors and 16,4% were cannabis users.[1253] Women accounted for approximately 4-5% of the total number of people registered.

In recent years, the number of people living with HIV has increased dramatically: there were 154 new HIV infections recorded in 2000, while in 2008 this figure had increased to 3,404 new infections.[1254] Until 1999, HIV was transmitted mostly sexually (98% of all cases), but as of 1999, HIV infections attributed to injection drug use had become predominant (80% of all cases of new infections in 1999, and in 65, 9% in 2006).[1255] As of 2008, there were 15,831 people infected with HIV in the country, among whom 7,373 (46.6%) were injecting drug users.[1256]

1252 UNAIDS, *2008 Report on the global AIDS epidemic* (Geneva, 2008), Annex.

1253 National informational and analytical centre on Drug control, under the Cabinet of Ministers of Uzbekistan, 2009.

1254 Ibid

1255 Ibid.

1256 Information reported from the National AIDS Centre as of 2006: ibid., pp. 51, 108-109.

2. NATIONAL PROGRAMMES AND STRATEGIES

Programme on HIV/AIDS

There is an Emergency Anti-Epidemics Commission and the Country Coordination Committee (established in connection with a grant received from the Global Fund to Fight AIDS, Tuberculosis and Malaria). These bodies are established under the Cabinet of Ministers of the Republic of Uzbekistan and the Council of Ministers of the Republic of Karakalpakstan (an autonomous republic within the Republic of Uzbekistan). People living with HIV/AIDS are members of the Country Coordination Committee.

The Republic of Uzbekistan has adopted and is implementing the *Strategic Programme of Counteraction to HIV-infection in the Republic of Uzbekistan for 2007 – 2011*.[1257] The Country Coordination Committee is responsible for its implementation and monitoring of activities is carried out based on national indicators in this sphere. Funding for the Strategic Programme is to come from both budget allocations by the Government of Uzbekistan and donor contributions. The national expert group reports that nearly 80% of the programme's funds are spent on HIV prevention measures.[1258] According to the national expert group, implementation of the Programme is intended to involve a wide range of partners and civil society along with representatives of vulnerable populations.

The principles of the Strategic Programme include the following:

- observance of human rights in accordance with national legislation, and the eradication of HIV-related stigma and discrimination;
- creation of a supportive legal and political environment for HIV prevention and treatment activities;
- guarantees of a multi-sectoral approach to address the HIV epidemic;
- large-scale involvement of civil society and people living with HIV in activities relating to HIV prevention;
- guarantees of a comprehensive approach to the reduction of vulnerability through adoption of safer behaviours; and
- guarantees of universal access of the population as a whole, and vulnerable groups specifically, to HIV prevention, treatment and support, including psycho-social and legal protection.

Major elements in the Strategic Programme are:

- improvements to the legal and regulatory framework;
- a single comprehensive system of monitoring and evaluation;
- HIV prevention interventions among at-risk populations and young people;
- activities to prevent mother-to-child transmission of HIV and transmission in health care facilities;
- treatment for sexually transmitted infections (STIs); and
- high-quality treatment for people living with HIV, as well as psychosocial support and care.

According to the Strategic Programme, HIV prevention efforts targeting particular "high-risk groups" include drug demand reduction initiatives and establishing a variety of "trust points" to provide low threshold services, such as distribution of information, condoms and sterile syringes. Currently there is one national AIDS Centre and 14 regional centres.[1259]

In December 2008, President of Uzbekistan signed Resolution "On additional measures of increasing effectiveness of HIV prevention in the Republic of Uzbekistan".[1260] This Resolution mandates establishment of a modern unified system of addressing HIV/AIDS, consisting of the National and regional AIDS centres. The Resolution created the National Commission on coordination of measures to address HIV prevention, whose mandate includes: coordination and partnerships of governmental agencies, ministries, national and local authorities and non-governmental organisations in the area of HIV prevention; development and implementation of National Plans on AIDS; monitoring and evaluation of HIV/AIDS response; and research and evaluation of safe and efficient methods of HIV prevention. Among others, the Commission is mandated to develop and oversee measures aimed at elimination of anti-social behaviours that lead to the spread of HIV, preservation and development of spiritual and moral foundations and traditional values of the nation of Uzbekistan, and to conduct of educational activities to this aim.

1257 Strategic Program Against HIV Infection in the Republic of Uzbekistan for 2007 – 2011, [Стратегическая программа противодействия распространению ВИЧ-инфекции в Республике Узбекистан], approved by the Deputy Prime Minister of the Republic of Uzbekistan, Order No 07/10-115 (3 July 2007).

1258 Information is provided by the national expert group.

1259 Information is provided by the national expert group.

1260 Resolution "*On additional measures of increasing effectiveness of HIV prevention in the Republic of Uzbekistan*" № ПП-1023, 26 December 2008.

The 2008 Resolution also adopted National Plan of Action on prevention of spread of HIV-infection in the Republic of Uzbekistan for 2009-2011, which includes HIV prevention measures, building institutional structure of AIDS centres and other health care facilities, ongoing continuing education of health care professional in the sphere of HIV/AIDS; organising educational activities in this area, and cooperation and coordination with international organisations. Within the *Programme "On implementation of a national response to HIV/AIDS, with a special focus on vulnerable populations"*, correctional facilities have implemented a project on HIV prevention among prisoners since 2006. This project is aimed at presenting detailed information on HIV and prevention measures to prisoners, who in turn will train other prisoners as peer educators. This programme is implemented with the Global Fund to Fight AIDS, Tuberculosis and Malaria funding.

The Republic of Uzbekistan has made welcome declarations that its response to HIV/AIDS will reflect a multi-sectoral approach of coordinated efforts of the entire community, and will reflect transparency and accountability. However, the national expert group has pointed out several problems pertaining to legislation and law enforcement regarding vulnerable populations, which factors impede implementation of HIV prevention and other health programmes. The experts indicate that one such problem is legislative ambiguity which leads to misunderstanding and different interpretation of certain legal and regulatory documents by various state agencies whose policies and programmes have an impact on HIV prevention efforts. (A number of recommendations in the final section of this country report are aimed at addressing this concern.)

Programme on narcotic drugs

The State Commission for Drug Control (under the Cabinet of Ministers of the Republic of Uzbekistan) and regional commissions for drug control are responsible for anti-trafficking activities and preventing drug use in the country. The Prime Minister chairs the State Commission; the head of each regional health care department is a member of the relevant regional commission.

In July 2007, the Government adopted a *"Programme of comprehensive measures against drug abuse and drug trafficking for 2007-2010"*.[1261] Funding for this Programme is allocated "within the limits of annual budget and extra-budgetary resources". The National Information and Analytical Centre for Drug Control oversees the implementation of the Programme. Important dimensions of this Programme include: ensuring social protection and employment of people with drug dependence; prevention of drug dependence and related offences; and strengthening health care services to people with drug dependence.

This Programme makes explicit provision for harm reduction measures. In particular, section 1(4) provides for "establishing, based on the local situation, a network of anonymous counselling units in order to implement low-threshold rehabilitation and prevention programmes, including harm reduction programmes." Section 5(2) provides for: increasing the range of services provided by harm reduction programmes (e.g., psychological counselling support); strengthening and establishing "trust points" for injection drug users; and developing a system of training workshops for people who use drugs to become peer educators.

Since 2004, the AIDS Foundation East West (AFEW) has implemented a programme that includes a component on "Reduction of drug demand and health care in prisons".[1262] In February 2005, the Chief of the Correctional Department of Uzbekistan [главное управление исполнения наказаний] issued an order "On establishing a Working group on implementation of a drug demand programme, and health protection in the penitentiary system of Uzbekistan", under which workshops, trainings and information sessions are carried out to increase prisoners' awareness of the harms connected with drug use and methods of preventing HIV, viral hepatitis and tuberculosis.

1261 *Program of comprehensive measures against drug abuse and drug trafficking for 2007-2010*, [Программа комплексных мер противодействия злоупотреблению наркотиками и их незаконному обороту на 2007-2010], No. 8/07 (2 May 2007).

1262 See more about AFEW's "Drug Demand Reduction Program in Uzbekistan, Tajikistan and in the Fergana region of Kyrgyzstan" at http://www.afew.org/russian/projects_sw_uz.php [программа снижения спроса на наркотики].

3. ADMINISTRATIVE AND CRIMINAL LAW PROVISIONS ON NARCOTIC DRUGS

For purposes of determining administrative or criminal liability for drug offences, amounts of narcotic and psychotropic substances are divided into "small" [небольшие], "exceeding small" [превышающие небольшие] and "large" [крупные] quantities. Applying these categories is within the authority of investigative bodies and courts, based on a list determined by the State Commission on Drug Control.[1263],[1264]

Uzbekistan does not have either criminal or administrative liability for the mere *use* of narcotic substances or for possession of paraphernalia for drug use (e.g., syringes, disinfectants and other equipment).

Administrative offences

According to the provisions of the *Code of Uzbekistan on Administrative Liability* (hereinafter "*Administrative Code*"), illegal production, acquisition, possession, transportation or mailing of narcotic or psychotropic substances in "small" [небольшие] quantities are administrative offences without intention to sell.[1265] The minimum age of administrative liability is 16.[1266]

Criminal offences

Offences involving "exceeding small" [превышающие небольшие] and "large" [крупные] quantities of controlled substances are criminal offences. The *Criminal Code of Uzbekistan* distinguishes between possession of drugs *with* or *without* intention to sell. The *Criminal Code* makes the following criminal offences:

- illicit production, acquisition, possession and other activities related to narcotic drugs and psychotropic substances *without intent to sell* are punishable by a fine or correctional labour for up to 3 years, arrest for up to six months or imprisonment for up to 3 years;[1267]
- illicit production, acquisition, possession and other actions with narcotic drugs or psychotropic substances with *intention to sell,* as well as actual *sale*, are punishable by imprisonment from 3 to 5 years; illicit sale of narcotic drugs or psychotropic substances in large quantities- is punishable by imprisonment from 19 to 20 years.[1268]
- "involvement" [вовлечение] in the use of narcotic or psychotropic substances is punishable by corrective labour for up to 3 years or imprisonment for up to 3 years; [1269]
- cultivation of illegal substances is punishable by a fine or correctional labour for up to 3 years or imprisonment for up to 3 years;[1270]
- violation of the rules of production and other handling (e.g., importation/exportation, distribution) of narcotic drugs and psychotropic substances is punishable by a fine, deprivation of the right to hold certain posts and professions for up to 5 years, or correctional labour for up to 3 years, or imprisonment for up to 5 years;[1271] and
- illegal acquisition of narcotic drugs and psychotropic substances is punishable with correctional labour for up to 3 years or imprisonment for up to 5 years.[1272]

1263 State Commission of Uzbekistan on Drug Control, "List of narcotic drugs determining small, exceeding small and large quantities when detected in illegal possession or trafficking" [Перечень наркотических средств с отнесением их количества к небольшим, превышающим небольшие и крупным размерам при обнаружении в незаконном владении и обороте], Decision No. 3 (22 May 1998).

1264 In Uzbekistan, there are three lists setting out varying degrees of legal control over activities related to controlled substances, such as exportation, importation, production and distribution. List I consists of substances for which all such activities are prohibited. List II substances are those for which such activities are strictly controlled. List III consists of substances for which such activities are limited to lesser extent. These lists are set out in Resolution No. 293 (31 July 2000) adopted by the Cabinet of Ministers.

1265 *Code of the Republic of Uzbekistan on Administrative Liability*, [Кодекс Республики Узбекистан об административной ответственности], Law No. 2015-XII (22 September 1994), Article 56 ["*Administrative Code*"].

1266 *Administrative Code,* Article 13.

1267 *Criminal Code*, Article 276.

1268 *Criminal Code,* No. 2012-XII, (22 September 1994), Article 273.

1269 *Criminal Code*, Article 274.

1270 *Criminal Code*, Article 270.

1271 *Criminal Code*, Article 275.

1272 *Criminal Code*, Article 272.

Penalties for the offence of illegal distribution (i.e., trafficking) increase for repeated offences. The *Criminal Code* does not provide for the confiscation of other property as a penalty for a criminal offence,[1273] but illegal drugs and drug-production equipment are confiscated.[1274] Being under the influence of alcohol or drugs while committing an offence is an aggravating circumstance.[1275]

Generally, 16 is the minimum age for criminal liability, but for some offences (e.g., illicit acquisition of narcotic drugs by theft or fraud), 14 is the minimum age.[1276]

Needle exchange programmes: legal issues

Criminal or administrative liability for possession of residual quantities of narcotic drug in a syringe depends on the type and amount of narcotic substance, according to the above-mentioned lists. The national expert group has pointed out that the law lacks provisions excluding harm reduction measures from possible criminal or administrative liability.[1277] The national expert group has noted that outreach workers, peer consultants and other syringe and needle exchange programme staff could theoretically run afoul of these provisions.

Compulsory drug testing by law enforcement authorities

Uzbek law provides several bases on which a person may be subjected to drug testing without his or her consent. One such instance is that police, investigative authorities and courts may order a person to be tested if there are "sufficient reasons to believe" [достаточные основания полагать] that he or she suffers from drug dependence, is in a state of intoxication, has used a narcotic or psychotropic substance without medical prescription, or is carrying a narcotic or psychotropic substance inside his or her body.[1278]

As the national expert group noted, this broad provision for involuntary drug testing could contribute to the further marginalization of people who use drugs and encourage corruption on the part of law enforcement officials. Such wide provisions on compulsory drug testing, vesting such extensive powers in law enforcement bodies, represent not only an inefficient use of limited resources but also an unjustified intrusion on human rights. For example, subjecting someone who has not committed any offence to involuntary drug testing violates the rights to liberty, security of the person and privacy, as well as the right to be free from non-consensual medical intervention; if test results are also used against the person in any sort of prosecution, it would also violate the right against self-incrimination.[1279] The only possible bases on which it might be justifiable for the state to infringe such human rights would be to intervene to prevent a serious risk of harm to oneself or to others; mere use of alcohol or drugs does not, by itself, establish this.

The national expert group has suggested that implementation of well thought-out public health laws, instead of criminal law and punishment, often allows for faster achievement of intended goals of protecting and promoting public health. Public health laws may be more flexible, allowing public health personnel to take more private measures tailored to the circumstances of the individual case. Factors underlying HIV risk behaviours — such as drug dependence, lack of information, poverty or violence — can often be resolved more effectively if one does not resort to criminal prosecution. Health care laws also allow taking more balanced steps with regard to ensuring individual freedoms and protection of public health — e.g., by ensuring that people living with HIV receive necessary consultations and access to health care services.

1273 Article 53 of the *Criminal Code* (confiscation of property) was repealed by legislation passed on 29 August 2001.

1274 *Law "On narcotic drugs and psychotropic substances"* [О наркотических средствах и психотропных веществах], Law No. 813-1, (19 August 1999), Article 37.

1275 *Criminal Code*, Article 56.

1276 *Criminal Code*, Article 271.

1277 Resolution "On judicial practices regarding offences related to trafficking of narcotics drugs and psychotropic substances" [О судебной практике по делам о преступлениях, составляющих незаконный оборот наркотических средств или психотропных веществ], No. 21 (27 October 1995). According to the Resolution, "involvement" [вовлечение] in narcotic drug use should be understood as "any deliberate actions aimed at enticing a person to use drugs (persuasion, offers, advice, etc) as well as deception, psychological or physical violence, restriction of freedom, etc, aimed at influencing a person to use drugs."

1278 *Law "On narcotic drugs and psychoactive substances"*, Law No. 813-I (19 August 1999), with amendments of 15 December 2000, No. 175-II, Article 35.

1279 *International Covenant on Civil and Political Rights*, 999 U.N.T.S. 171 (1966), Articles 7, 9, 14, 17.

Groups at high risk of HIV: criminal and administrative law issues

Sex between adult men

Currently, the *Criminal Code* makes consensual sex between adult men a crime, with a penalty of imprisonment for up to three years.[1280] This contravenes international human rights law, including rights to non-discrimination and privacy, and is counter-productive in that it undermines HIV prevention efforts and access to health information and services among men who have sex with men.[1281] The UN Human Rights Committee has ruled that the right to privacy under the *International Covenant on Civil and Political Rights* (Article 17) is violated by such laws criminalizing consensual sex between adults of the same sex. The Committee has specifically noted that:

> …the criminalization of homosexual practices cannot be considered a reasonable means or proportionate measure to achieve the aim of preventing the spread of HIV/AIDS… [B]y driving underground many of the people at risk of infection … [it] would appear to run counter to the implementation of effective education programmes in respect of the HIV/AIDS prevention.[1282]

It is recommended that Uzbekistan repeal this discriminatory provision in the *Criminal Code*.

HIV exposure and transmission

Article 113 of the *Criminal Code* of Uzbekistan provides for criminal liability for the following:

- "knowingly exposing someone to venereal disease" is punishable by a fine, correctional work for up to one year, or arrest for up to three months;
- transmission of venereal disease by a person who knew of his or her infection is punishable by arrest from three to six months or imprisonment for three to five years;
- knowingly exposing someone to "AIDS disease" and the transmission of "AIDS disease" is punishable by imprisonment from eight to ten years.

Having a specific criminal offence singling out HIV exposure and negligent transmission runs contrary to internationally recommended policy, in part because it stigmatizes people living with HIV and creates a further disincentive for HIV testing and an additional barrier to access to health services. The *International Guidelines on HIV/AIDS and Human Rights* recommend against such an approach: criminal legislation should not include specific offences regarding HIV transmission or exposure, and the scope of applying criminal law should be limited to those cases where someone acts with malicious intent to transmit HIV and does in fact transmit the virus.[1283]

Criminalization of sex workers

Under the *Administrative Code* (Article 190) sex work is an administrative offence punishable by a fine. The same offence repeated within a year after a first penalty leads to a higher fine. Under the *Criminal Code* (Article 131), "organising brothels and pimping with the purpose of receiving profit or other immoral reasons" is punishable with a fine or correctional labour for up to three years. However, criminalizing sex workers contributes to their further stigmatization and marginalization, putting them at greater risk of human rights abuses and exacerbating vulnerability to HIV. It is recommended to decriminalise sex work, in compliance with international standards. The *International Guidelines on HIV/AIDS and Human Rights* recommend that "with regard to adult sex work that involves no victimization, criminal law should be reviewed with the aim of decriminalising and legally regulating occupational health and safety conditions to protect sex workers and their clients, including support for safe sex during sex work".[1284]

1280 *Criminal Code*, Article 120.

1281 UNAIDS/OHCHR, *International Guidelines on HIV/AIDS and Human Rights* (2006 Consolidated Version), paras. 22(h), 123-124; UNAIDS, *Policy Brief: HIV and Sex Between Men* (August 2006).

1282 UN Human Rights Committee, *Toonen* v. *Australia*, Communication No. 488/1992, UN Doc. CCPR/C/50/D/488/1992 (31 March 1994), para. 8.5.

1283 Joint United Nations Programme on HIV/AIDS & Office of the High Commissioner for Human Rights, *International Guidelines on HIV/AIDS and Human Rights,* Guideline 4, para. 21(a); UNAIDS, *Policy Brief: Criminalization of HIV Transmission* (2008).

1284 *International Guidelines on HIV/AIDS and Human Rights*, Guideline 4, para. 21(c).

4. HEALTH SYSTEM AND SERVICES

The Constitution of the Republic of Uzbekistan guarantees good-quality health care to all citizens. The government has established a guaranteed scope of health care services provided for free at state health care facilities.[1285] All health services outside the guaranteed scope of services are paid for privately by patients. Access to health services for migrants and refugees is equal to that of citizens of Uzbekistan.[1286]

Primary health care services are provided at health care facilities in the district where a patient is registered as a resident. According to the national expert group, drug use cannot constitute a satisfactory reason for denying people treatment for HIV, hepatitis, tuberculosis or drug dependence. Patients living with HIV are eligible to receive anti-retroviral treatment (ART) and, if opioid-dependent, opioid substitution treatment (OST), for free. Such treatment programmes are funded by the Global Fund to Fight AIDS, Tuberculosis and Malaria. However, there is limited access to health services for people who lack a permanent place of residence. At present, one drop-in centre operates in the city of Samarkand under an Uzbek-Swiss project on harm reduction among people who inject drugs.

Free treatment for certain categories of diseases

Uzbek law contains the categories of "socially significant diseases" [социально значимые заболевания][1287] and "diseases that pose a threat to others" [заболевания, представляющие опасность для окружающих],[1288] which categories are defined by the Cabinet of Ministers. "Social significant diseases" include: tuberculosis, sexually transmitted infections (STIs), HIV/AIDS, cancers, malignant growths, leprosy and mental disorders (including drug dependence). Free health services are guaranteed by the government to all patients with social diseases. Therefore, all people with social diseases receive medical assistance and free medication at outpatient facilities, and treatment in inpatient facilities. HIV/AIDS and hepatitis are also classified as diseases posing a threat to others; persons suffering from such diseases are also eligible to receive free health services at specialized facilities within the public health care system.

Excerpts from interviews conducted by the national expert group:

"Marat", 32 years old, uses drugs:

"It is actually pretty easy to receive health care services. One can go to a polyclinic. But I rarely go there. I know that I would need a passport with the certificate of domicile to be admitted to the hospital.

I have undergone [drug dependence treatment] five times. The first time I thought that after treatment I would quit. But they couldn't help me then. Withdrawal symptoms were so violent that I escaped on the second day. Then, I went for drug dependence treatment in order to reduce the dose. But there is always a shortage of medications at hospitals. The last time was a year ago. The medication situation had improved a little. Treatment at a rehab centre is free, but when there are no medications I need, I have to buy them. [If] you break the rules, they discharge you from the hospital. In general, they don't keep patients there against their will. Get treatment if you want to, and leave if you don't. I only know that in case of a compulsory treatment, you have to stay at the hospital for the whole period.

Police and then courts refer people for [compulsory treatment]. There is also compulsory treatment in the penitentiary. But this "treatment" doesn't work at all. I was told that. Even after routine compulsory treatment [outside of prisons], no one quit. No use. If you don't want to [quit yourself], it's all useless. As far as rights go – when the police files for a compulsory treatment order, who would ask about my rights?

1285 *Law "On health protection"* [Об охране здоровья граждан], Law No. 265-I (29 August 1996), Article 8.

1286 Ibid., Article14: "Foreign citizens on the territory of the Republic of Uzbekistan are guaranteed a right to health protection in accordance with international agreements of the Republic of Uzbekistan. Stateless persons permanently residing in Uzbekistan are provided with the same health services as citizens of the Republic of Uzbekistan. The procedure of rendering medical assistance to [these] persons is ….determined by the Ministry of Health of the Republic of Uzbekistan."

1287 The list of social diseases was approved by the Cabinet of Ministers of the Republic of Uzbekistan: Resolution "On approving the list of social diseases and establishing privileges for people suffering from them" [Об утверждении перечня социально значимых заболеваний и установлении льгот лицам, страдающим ими], Resolution No. 153 (20 March 1997).

1288 The list was adopted by the Cabinet of Ministers of the Republic of Uzbekistan, Order No. 96 (20 February 1997).

I am now on a waiting list for methadone, four months already. I am waiting for a vacant space, for my turn for substitution treatment. I know four drug addicts who go there and get pills. They're happy. The most important this is they don't go looking for drugs. They work. One of them got married. It's hard to get the ST – long waiting list. It's a pity they only offer it at the narcological facility.

[Answering a question about what needs to be changed to improve access to health care services and HIV prevention and treatment for drug users] *Probably, there is no need for registration of drug users. There is no use of it anyway. Those who use drugs, use them anyway. Those who want treatment, go for treatment. I think substitution treatment should be extended".*

Sex worker, name withheld

[Answering a question about receiving health care services]: *Theoretically, there is a chance, I can go to a polyclinic. Going to an STI clinic…is problematic. It is better to do it unofficially, go to doctors you know – there will be no publicity.*

[Answering a question about denial of health care]: *Yes, there were cases when I was denied [health care], time and again. The reason: I have no certificate of domicile at the place where I live. I have my own gynecologist, I pay money, get information and treatment if I need to.*

[Answering a question about what needs to be changed to improve access to health care services and HIV prevention and treatment]: *There is a need to increase anonymous rooms at STI and gynecological facilities. Generally, stop persecuting us. Our work should be made legal.*

4A. DRUG DEPENDENCE PREVENTION AND TREATMENT

Under the *Law "On narcotics drugs and psychotropic substances"*,[1289] the government guarantees people with drug dependence narcological assistance including health examinations, counselling, diagnostics, treatment and medical and social rehabilitation services. In accordance with the law, narcological assistance to patients with drug dependence is provided at their request or with their consent, while minors at the age younger than fourteen years are treated at the request or with the consent of their parents or other legal guardians. People with drug dependence who *voluntarily* seek drug dependence treatment are guaranteed confidentiality of treatment at their request.[1290] The Ministry of Health has adopted standards of narcological assistance, described by the national expert group as being based on comprehensive, step-by-step, and differential approach to treatment including modern methods of examination and treatment.[1291]

However, as recommended by the national expert group, given the growing problem of drug dependence, a special law supporting prevention and treatment of drug dependence is advisable. Currently, the *Law "On narcotics drugs and psychotropic substances"* contains only three articles which govern drug dependence treatment, and this legislation is largely aimed at prohibiting various drug-related activities, rather than a health-based response. Creating a separate legislative framework, with clear responsibility for the Ministry of Health in preventing and treating drug dependence would be helpful, as it would counteract what remains a dominant focus on criminalizing people who use drugs. In this regard, the Ministry of Health has developed a suggestion to the Cabinet of Ministers about developing and adopting a new *Law "On narcological assistance"*. The adoption of such a law has been included in the list of activities approved by the State Commission on Drug Control.[1292]

1289 *Law "On narcotic drugs and psychotropic substances"*, Article 44.

1290 Ibid.

1291 Ministry of Health, Order "On Approving Standards of Diagnosis and Treatment of Patients with Drug Dependence" [Об утверждении стандартов диагностики и лечения наркологических больных], Order No.19 (15 January 2004).

1292 State Commission on Drug Control, Resolution "On the Program of comprehensive measures to counteract illicit drug abuse and trafficking for 2007-2010", Resolution No. 8/07 (2 May 2007).

Registration of people who use drugs

As is common in the region, Uzbekistan maintains a system of registration of persons with drug dependence and persons who use drugs.[1293] Registration and deregistration is done by territorial narcological facilities based on the decision of a health advisory board. A person may be removed from the registry, based on a decision of a health advisory board, in the following situations:

- three years' "remission" (i.e., no drug use);
- sentence to imprisonment for more than one year;
- lack of information about a patient for more than one year; or
- death of the patient.

The registry is maintained by territorial narcological facilities and law enforcement agencies. The national expert group has noted that medical facilities report information about persons who are registered to law enforcement agencies, including cases in which people seek overdose treatment. This sharing of patient information is based on a joint order from the Ministries of Health and Internal Affairs.[1294]

The fear of negative consequences flowing from being registered as a drug user will, for some people, create a further barrier to seeking drug dependence treatment. Such consequences include the loss of confidentiality, discrimination (as some rights of people who use drugs are restricted by law as described further below, or greater exposure to police attention and possible criminal prosecution in future. Seeking health services should not come with these consequences; this undermines efforts to protect and promote the health of some of those most vulnerable, including reducing the risk of infection with HIV and other blood-borne diseases associated with risky drug use practices. It is recommended to abolish the practice of drug user registration and the practice of reporting to law enforcement agencies registered persons who seek medical assistance, including in cases of overdose.

Compulsory drug dependence treatment

Uzbek law maintains that, as a general rule, voluntary, informed consent is a prerequisite for any medical intervention.[1295]

However, as noted above in Section 3, compulsory drug testing may be imposed by law enforcement authorities in a number of circumstances. In addition, according to the national expert group, compulsory testing is also performed in cases where it is necessary to decide on imposing compulsory drug dependence treatment in specialized health care facilities or in prisons.

In Uzbekistan, compulsory drug dependence treatment may be imposed by court order in two circumstances.[1296]

First, a court may order compulsory treatment for drug dependence in the case where a person with drug dependence, as established by medical evidence, has committed a crime. This compulsory treatment will be ordered in addition to the criminal sentence imposed.[1297] If the sentence consists of a penalty other than imprisonment, the person undergoes compulsory treatment at health facilities. If the sentence in-

1293 Article 46 of the *Law "On narcotic drugs and psychotropic substances"* provides the statutory basis for the regulations governing drug user registration in Uzbekistan. Registration is done in accordance with the Order of the Ministry of Health "On Approving the Instruction for Registration and Surveillance of Persons Allowing Non-medical Consumption of Narcotic and Psychotropic Substances, Persons with Drug or Substance Dependence" [Об утверждении инструкции о порядке взятия на учет и наблюдения за лицами, допускающими немедицинское потребление наркотических средств и психотропных веществ, больными наркоманией и токсикоманией], Order No. 1494 (15 July 2005).

1294 Ministry of Internal Affairs/Ministry of Health, Joint Order "On Approving the Instruction for the Procedure of Organizing Prevention Activities of Internal Affairs and Health Care Agencies with Persons Abusing Alcoholic Drinks or Narcotic Substances and Referrals to Obligatory Treatment of People with Chronic Alcoholism and Drug Dependence" [Об утверждении инструкции о порядке организации профилактической работы органов внутренних дел и здравоохранения с лицами, злоупотребляющими спиртными напитками или наркотическими средствами, и направления на принудительное лечение больных хроническим алкоголизмом или наркоманией], Order No. 326/599 (27 December 1994).

1295 *Law "On health protection"*, Article 24. In emergency situations where a patient is not capable of expressing his or her will, a council of physicians makes the necessary decisions about medical intervention. According to the national expert group, if a person refuses medical assistance, the possible consequences of that refusal are supposed to be explained, with this confirmed by a written record in the person's medical file that is signed by the health worker and the patient and certified by witnesses.

1296 Law "On compulsory treatment of persons with chronic alcohol, drug or other substance dependence" [О принудительном лечении больных хроническим алкоголизмом, наркоманией или токсикоманией], Law No. 753-xii (9 December 1992), with amendments by Law No. 175-II (15 December 2000), Regulation No. 73-I of the Supreme Council of Uzbekistan (6 May 1995), Regulation No. 371-I of the Supreme Council (27 December 1996), Law No. 550-I (26 December 1997), and Regulation No. 714-I (24 December 1998).

1297 *Criminal Code*, Article 96.

cludes imprisonment or other custodial penalty, the drug dependence treatment will be imposed in the custodial setting; if, upon discharge from prison, further treatment is ordered, that treatment will take place in health facilities.

It should be noted that international drug control treaties explicitly allow States Parties to include, in their domestic legislation, *alternatives* to conviction and incarceration for drug offences, including providing treatment and rehabilitation services, instead of adding these on top of criminal sentences.[1298] There appears, therefore, to be room for Uzbekistan to change its current legislative approach of imposing compulsory treatment *in addition to* other criminal punishment.

Second, compulsory treatment may also be prescribed in cases where a patient with drug dependence disturbs the public peace, violates the rights of other people or "poses a threat to the safety, health or morals of the population".[1299] Such a court order is made based on documented medical evidence and upon the request of either Internal Affairs agencies or a petition by family members or relatives of the patient, by co-workers or by health care personnel. A person ordered to undergo drug dependence treatment can appeal the order, as can a prosecutor. If the patient does not appear for treatment as ordered, without a plausible reason, he or she is subject to arrest by law enforcement agencies. A committee of the health facility providing treatment determines whether to continue or discontinue compulsory treatment.

International organizations underline the principle that drug dependence treatment should generally be voluntary.[1300] As a general proposition, compulsory medical treatment violates human rights, including to liberty, security of the person and privacy,[1301] and should be applied only in extreme, clearly defined cases with a view to preventing a person from causing imminent, serious harm to himself or herself or to others. There appears to be a need to tighten current Uzbek law to circumscribe more narrowly the bases on which compulsory treatment may be imposed.

Opioid substitution treatment

From 2004 to 2009, Uzbekistan offered opioid substitution treatment (OST), in the form of both methadone and buprenorphine, under a regulation adopted by the State Commission for Drug Control.[1302] Until 2008, OST was provided through one pilot project at the Tashkent City narcological facility.[1303] According to reports, in 2008, the Ministry of Health had been considering expanding OST projects in two more regions of the country (Samarkand and Bukhara), but instead in 2009 discontinued all existing pilot projects.

Apart from the above Regulation, the legal basis for OST was provided for in the *Law "On narcotic drugs and psychotropic substances",* which states that "means and methods that are not prohibited by the Ministry of Health of the Republic of Uzbekistan are used for drug dependence treatment."[1304] The selection of patients for substitution treatment was done by a special Advisory Committee, whose composition was approved by the head physician of the narcological dispensary. The duration of OST was not limited and was defined individually upon agreement with the patient. Under the OST pilot project, both detoxification and short-term and long-term substitution treatment were provided. Patients participated in discussion of treatment and choice of doses. Substitution medications were not dispensed to take home, and any decision to discontinue OST was adopted only by the advisory board. During outpatient substitution treatment, patients were tested for the use of illicit drugs and psychoactive substances to determine if the patient used other drugs. If patient used other drugs, substitution treatment was discontinued and the patient dismissed from the programme.

1298 *Single Convention on Narcotic Drugs*, 1961, UN, 520 UNTS 331, as amended by the 1972 Protocol, Article 36(2); *Convention on Psychotropic Substances*, 1971, UN, 1019 UNTS 175, Article 22; *Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances,* 1988, Article 3(4).

1299 *Law "On compulsory treatment of persons with chronic alcohol, drug or other substance dependence"*, Article 1.

1300 UNODC and WHO, *Principles of Drug Dependence Treatment: Discussion Paper* (March 2008).

1301 *International Covenant on Civil and Political Rights*, 999 U.N.T.S. 171 (1966), Articles 7, 9 and 17; *Universal Declaration of Human Rights*, UN General Assembly Resolution 217A (III), UN Doc. A/810 (1948), Articles 3 and 12.

1302 State Commission for Drug Control, Regulation "On the Implementation of the Pilot Project for Administering Substitution Treatment using Methadone" ["О реализации пилотного проекта по применению заместительной терапии с использованием препарата метадон"] (5 October 2003).

1303 Provision of substitution treatment is governed by the Regulation "On the conditions and procedures of substitution treatment of the Republic of Uzbekistan", approved by the Ministry of Health's Order "On Providing Substitution Treatment Under the Strategy of Harm Reduction among Persons Using Injection Drugs" [О применении заместительной терапии в рамках стратегии уменьшения вреда среди лиц, употребляющих наркотики путем инъекций], Order No. 160 (9 April 2004).

1304 *Law "On narcotic drugs and psychotropic substances"*, Article 45.

The discontinuation of OST projects in Uzbekistan is a very disturbing and disappointing development. This decision of the government is contrary to international obligations of the Republic of Uzbekistan to guarantee the highest attainable right to health to its people. It runs contrary to the best international practices of harm reduction, including HIV prevention and effective drug dependence treatment. This decision leaves hundreds of patients without necessary treatment, and at risk of returning to illicit drug use, at risk to be arrested, detained, convicted and imprisoned for drug use (on the basis of their health status). The government of Uzbekistan is recommended to reinstitute the OST programmes immediately, and adopt rigorous quality monitoring and evaluation of these programmes.

Overdose prevention

At present, the response to cases of overdose consists of detoxification treatment and the management of symptoms. Naloxone, an opioid antagonist medication used to counter the effects of opioid overdose (including suppression of the central nervous and respiratory systems), is listed by the WHO as an essential medication for treating poisonings.[1305] In 2009 Uzbekistan included naloxone on the list of essential medicines, which means that it will be procured by the government. This is a welcome development which will make naloxone more accessible to people who need it. However, there is more than could be done – according to international recommendations, naloxone should be made available to people who use drugs, their friends and relatives (not only through health care workers). This will reduce instances of death as a result of overdose.

4B. HIV PREVENTION AND TREATMENT

HIV prevention among people who use drugs

There are more than 230 "trust points" in Uzbekistan for HIV and STI prevention among "vulnerable groups". Trust points provide information and education, counselling, condoms, disinfectants and syringe and needle exchange, in addition to coordinating outreach activities with vulnerable populations.[1306] Trust points function at the AIDS centres and at some other health care facilities. The programmes were initially funded by the government; since 2005, they have been funded by the Global Fund to Fight AIDS, Tuberculosis and Malaria. According to the national expert group, trust points respect the principles of confidentiality and anonymity; records are kept using coding systems.

The collection and disposal of syringes and needles, as well as the involvement in trust points' work of people who use or have used drugs, are regulated by guidelines approved by the Head State Sanitary Physician of the Republic.[1307] Trust points train people who use drugs to work as volunteer peer outreach workers. According to the national guidelines, outreach workers:

- establish and maintain contact with people who use drugs;
- collect information about drugs used and problems of people who use them;
- provide advice on where to get health care assistance or undergo anonymous HIV testing;
- refer people to other services, such as drug dependence treatment facilities;
- provide information on how to reduce the risks of harm associated with drug use (e.g., less risky injection practices, overdose prevention) and on safer sex;
- discuss risky behaviours with members of the target group; and
- provide information materials, education and the means of protection.[1308]

The national expert group has indicated that trust points' "low-threshold" services to injection drug users are insufficiently integrated into the network of drug dependence treatment facilities, which mainly aim at full abstinence. Additionally, some trust points are located in inconvenient places and have no separate entrance, and their hours of operation are not always convenient for the intended population. Some trust

1305 WHO, WHO Model List of Essential Medicines, regularly updated, online: http://www.who.int/medicines/publications/essentialmedicines.

1306 Ministry of Health, Regulation "On trust points" [О кабинетах доверия], Order No. 420 (23 September 2003).

1307 Head State Sanitary Physician, "Guidelines on the establishment and improvement of activities of trust points" [Методическое пособие «Организация и совершенствование работы кабинетов доверия»] (8 May 2006).

1308 Ibid.

points do not have separate staff, and their functions are imposed on physicians as additional tasks. The national expert group has identified these as issues of concern that should be addressed.

HIV testing

Uzbekistan has a specific *Law "On prevention of disease caused by a human immunodeficiency virus (HIV-infection)"* (hereinafter the *Law "On HIV"*).[1309] This short statute consists of 13 articles and regulates the rights of patients and HIV testing procedures, as well as establishing liability for HIV transmission (punishment for which is determined in the Criminal Code). According to this law, citizens of Uzbekistan, as well as foreign nationals and stateless persons in the country, are entitled to voluntary, anonymous HIV testing with guaranteed confidentiality.[1310] Regulations approved by the Head State Physician of the Republic ensure patients' rights to anonymity and confidentiality of testing and medical secrecy as well as the accessibility of testing, and guarantee pre- and post-test counseling.[1311]

Pre- and post-test counselling is delivered by health workers, staff of trust points that provide harm reduction services, outreach workers, psychologists and peer consultants. HIV testing is only done at state AIDS centres. The results of HIV tests are filed in a special form with identification, passport data, address, date of testing and the test results. All this information is entered in a database of people with HIV. The national expert group has noted that, in order to maintain confidentiality, information is sent to public health authorities with the stamp "for official use only". The database may be accessed by specialists engaged in prevention, surveillance, and treatment of HIV.

According to the national expert group, there is a need to further improve HIV testing systems in the country, by making changes to existing legal and regulatory documents of the Ministry of Health. According to the experts, it is necessary to improve the quality of diagnosis, including introducing third and fourth generation testing technology that would considerably decrease a number of false positive results.

Compulsory or mandatory testing for HIV and other diseases

According to the national expert group, HIV testing is mostly voluntary. However, the legal and practical reality includes testing that is either mandatory or compulsory in various instances, both of which raise human rights and public health concerns.

Justifiably, HIV testing is mandatory in Uzbekistan for those donating blood.[1312] However, HIV testing is also mandatory for foreigners seeking to enter Uzbekistan: in order to obtain a visa to enter Uzbekistan, foreigners must present a certificate confirming HIV-negative status.[1313] Foreigners within Uzbekistan who test HIV-positive (as a result of voluntary testing) may be deported.[1314] The deportation procedure is not regulated by law; however, the practice is for territorial health bodies to submit the information to the Ministry of Foreign Affairs, which arranges the deportation. However, prohibiting the entry of, or deporting, foreigners with HIV is not supported by international guidelines.[1315]

The law of Uzbekistan also mandates testing before marriage for HIV, STIs, tuberculosis and drug dependence.[1316] If testing determines that one or both parties planning to marry have one or more of the above conditions, registration of marriage is done after confirming awareness of both parties about the results of these tests. If testing reveals a condition that requires immediate treatment, the person is referred to treatment facilities.

1309 Law"On prevention of disease caused by a human immunodeficiency virus (HIV infection)" [О профилактике заболевания, вызываемого вирусом иммунодефицита человека (ВИЧ-инфекции)], Law No. 816-1 (19 August 1999) [hereinafter Law "On HIV"].

1310 *Law "On HIV"*, Article 3.

1311 Head State Sanitary Physician, "Sanitary rules and procedures for HIV/AIDS testing and treatment for people with HIV/AIDS" [Санитарные правила и нормы по медицинскому освидетельствованию на ВИЧ/СПИД и организации медицинской помощи больным ВИЧ/СПИД], No. 0187 (6 October 2005) [hereinafter "Sanitary Rules"].

1312 Sanitary Rules.

1313 *Law "On HIV"*, Article 12.

1314 Ibid., Article 6.

1315 *UNAIDS/IOM Statement on HIV-AIDS-related travel restrictions* (2004); *International Guidelines on HIV/AIDS and Human Rights*, 2006 Consolidated Version (Geneva: UNAIDS & OHCHR, 2006), para. 127.

1316 Regulation "On Medical Testing of Persons Planning to Marry" [О медицинском обследовании лиц, вступающих в брак], Regulation No. 365, Annex 1 to the Resolution of the Cabinet of Ministers, "On Approving the Provision of Medical Testing of Persons Planning to Marry" (25 August 2003). Paragraph 4 indicates that persons entering marriage must undergo medical testing for psychological, narcological and venereal diseases, as well as tuberculosis and HIV/AIDS.

HIV testing is also effectively compulsory in some instances. Uzbek law makes it an administrative offence for a person to avoid testing for HIV or STIs if there is "sufficient information" [достаточные данные] to believe he or she is infected, as well as for a person to refuse to disclose the source of infection with HIV or an STI.[1317] Regulations also require HIV testing of people identified as sexual contacts of persons living with HIV.[1318] In addition, compulsory HIV testing may be conducted when requested by police.[1319] Such widespread imposition of HIV testing without consent is not justifiable or necessary. The national expert group has reported that, based on interviews it conducted as part of the assessment, involuntary testing is often imposed on sex workers and people who use drugs,[1320] a practice which is further contrary to international standards.[1321]

A number of these articles and practices contradict the right to voluntary medical examination for HIV infection, and the Constitution and other legislation of Uzbekistan. In addition, according to international standards, an HIV test should be done on a voluntary basis only, except for obligatory tests for donors of blood and organs.[1322] If HIV testing is ever to be imposed without consent, then it requires a process clearly set out in law, with a requirement that such measures be taken only in exceptional circumstances and with adequate justification that must be considered by an independent, judicial body, and with the most limited infringement of human rights possible.[1323] In addition, the national expert group has expressed concern that involuntary HIV testing risks driving "at risk" groups underground and creating additional barriers to effective HIV prevention and treatment.

HIV treatment

HIV treatment is carried out on the basis of an Order adopted in 2007 by the Ministry of Health, which established major strategic goals and directions in diagnosis, treatment, care and support for persons with HIV.[1324]

This Order mandated implementation of WHO HIV protocols adapted to the situation in Uzbekistan, voluntary counselling and testing, provider-initiated counselling and testing. Following this Order the system of HIV-labs was restructured; developed a comprehensive plan of carrying out express-tests, in particular in maternity wards, STI clinics, TB dispensaries, drug dependence treatment clinics, "friendly cabinets" and "trust points". The Order established a system for monitoring of prescription and dispensation of ART-therapy, registry of people with HIV in infectious diseases database; the system of continuous dispensation of ART-therapy is developed on the basis of AIDS centres and other health care facilities, psychological counselling and assistance is provided.

Patients' rights, including confidentiality

The right to qualified health care assistance is provided for in the *Law* "*On protection of public health*", in accordance with which patients have the right to be accorded respectful and humane treatment by health and service staff and the right to give voluntary consent to, or decline, medical intervention.[1325]

In addition, this law provides that information about the fact of seeking medical assistance, health status of a person, diagnosis and other information obtained during testing and treatment, constitute "medical secrets" which must be kept confidential.[1326] The *Law "On HIV"* also states that the government guarantees the safety, confidentiality and anonymity of HIV testing.[1327] Breaching the obligation of medical secrecy in Uzbekistan leads to administrative liability.[1328]

1317 Administrative Code, Articles 57 and 58.

1318 Sanitary Rules.

1319 Ibid, para. 13.

1320 See Report of the Republic of Uzbekistan, pp. 44.

1321 *International Guidelines on HIV/AIDS and Human Rights*, 2006 Consolidated Version, para. 22(j).

1322 *UNAIDS/WHO Policy Statement on HIV Testing* (June 2004).

1323 Guidelines such as the UN's *Siracusa Principles* on permissible limitations on human rights should be complied with in any legislative provision that would allow involuntary testing or treatment: UN Economic and Social Council, *Siracusa Principles on the Limitation and Derogation Provisions in the International Covenant on Civil and Political Rights*, UN Doc. E/CN.4/1985/4, Annex (1985).

1324 Ministry of Health, Order "On Development of Prevention Activities and establishment of medical and social assistance in relation to HIV-infection in the Republic of Uzbekistan" [О п О совершенствовании профилактических мероприятий и организации медико-социальной помощи в связи с ВИЧ-инфекцией в Республике Узбекистан», Order No. 480 (30 October 2007).

1325 *Law "On protection of public health"*, Article 24 (1).

1326 Ibid., Article 45.

1327 Law "On HIV", Article 4.

1328 Under Article 46 of the *Administrative Code*, disclosure of a patient's confidential information and other similar information that may possibly cause moral or material damage to a citizen and his or her rights, freedoms and legal interests, is punishable by a fine.

In the event that a patient feels his or her rights have been violated, the patient may file a complaint with the manager or another official at the health care facility, a higher management body, or directly with the court.[1329] Where a violation of rights is found to have caused harm to the health of a person, the guilty party (individual person or organization/facility) is legally liable and must compensate the victim for damages in accordance with the legislation. In this case, compensation for such damage does not exempt health care staff from additional disciplinary, administrative or criminal liability in accordance with the law.[1330]

However, as the national expert group has noted, the anonymity and confidentiality of HIV testing is infringed by other articles in the *Law "On protection of public health"* and the *Administrative Code*. While the former "guarantees" anonymity and confidentiality of a patient, at the same time it also states that sharing of medical information is allowed without a patient's consent:

(1) if there is a threat of spreading infectious diseases (including HIV), poisoning or harm to a large number of people; or
(2) in response to an inquiry from investigative bodies, a prosecutor's office or a court in relation to an investigation or court proceeding.[1331]

Since the *Administrative Code* makes it an administrative offence for a person to avoid testing if there is sufficient information [достаточные данные] that he or she might have HIV,[1332] and this provision of the *Law "On protection of public health"* allows disclosure of a person's HIV status without consent when there is a perceived threat of HIV transmission, in practice the law provides for potentially very significant exceptions to the legal "guarantees" of confidentiality. Furthermore, disclosing confidential health information to law enforcement authorities upon request, particularly if that information can be used for administrative or criminal prosecutions or in other ways that infringe upon liberty, security of the person or privacy, is an obvious disincentive for people to seek health services, particularly in relation to such sensitive and stigmatized health conditions as HIV, STIs or drug dependence.

Additionally, in order to better guarantee protection of patients rights, the expert group recommends to develop and adopt a law "On health care activity and patients' rights" which would fully incorporate international principles related to patient's rights.

1329 *Law "On protection of public health"*, Article 24(2).

1330 Ibid., Article 46.

1331 Ibid., Article 45.

1332 Administrative Code, Article 58.

5. PRISONS

As of August 2006, the national prison administration estimated that there were some 48,000 prisoners in custodial facilities in Uzbekistan.[1333] Of the total number of prisoners, 21.4% of them are imprisoned for drug-related crimes: 24.2% of these prisoners serve their terms in colony settlements, 33.9% in colonies with a "standard security" regime, 20.8% in colonies with a "strict security" regime, 9.3% in colonies with a "mixed" security regime, 4.6% in "special" regime colonies, 6.9% in colonies providing treatment, and 0.05% in prisons.[1334] According to the information presented by the experts, during the last years, following reforms of the penitentiary system, the prison population in Uzbekistan has been decreasing.

Uzbekistan's penal system operates under the Ministry of Internal Affairs. The national expert group indicates that working groups on HIV prevention in the penitentiary are mandated to ensure implementation of the strategic programme on HIV prevention in correctional facilities. In 2005, the Main Penal Directorate of the Ministry of Internal Affairs issued a decree establishing a working group on drug demand reduction and health protection in the penal system, which group included AIDS Centre specialists, staff of the Main Penal Directorate and the Health Department of the Ministry of Internal Affairs and NGO representatives.[1335]

In the penal system of Uzbekistan, the national budget is supposed to cover the costs of providing health care services to prisoners, as well as their food, clothes, and personal hygiene effects.[1336] However, as the national expert group has noted, laundry soap is the only personal hygiene item that is provided to prisoners free of charge. Prisoners must purchase all other personal care items, including soap, toothpaste, razors, combs and towels.[1337] The experts have noted that this lack of essential items impedes efforts to prevent the spread of infectious diseases, including HIV and hepatitis C, among prisoners, and contradicts the *Penal Code* "guarantee" that the state pays for health and sanitary services to prisoners.

Pre-trial detainees and prisoners with HIV are not segregated based on HIV status.[1338] According to the national expert group, they have the same opportunities to participate in educational, labour, professional and other programmes as other prisoners, and have access to the whole range of available counselling and additional services provided at prisons.[1339]

HIV testing and treatment in prisons

According to the Ministries of Health and Internal Affairs, HIV testing in penal institutions is conducted voluntarily, accompanied by pre- and post-test counselling.[1340] The administrative and health care staff of these institutions must keep confidential information on persons with HIV infection or AIDS. In each pre-trial detention centre and penal institution the head of the facility assigns a health care worker responsible for voluntary testing, pre- and post-test counselling, and registration and follow-up of people living with HIV and AIDS. As a rule, on arrival at a pre-trial detention or penal facility, a doctor (or nurse)

1333 International Centre for Prison Studies, World Prison Population List (8th edition), King's College, London, online version in English, via http://www.kcl.ac.uk/depsta/law/research/icps/publications.php/.

1334 People who committed less serious offences as a result of negligence and offences that do not pose a serious social threat are sentenced to *colony settlements*; persons who committed serious and especially serious crimes for the first time serve their sentence in *standard security regime colonies*; *maximum regime colonies* house repeat offenders and those sentenced for intentional, premeditated crimes; *special regime colonies* house male prisoners considered to be especially dangerous recidivists and sentenced to life imprisonment; persons sentenced to prison terms serve in *prisons* (cell type penitentiary institutions, with more restriction to movement than in the colony).

1335 Main Penal Directorate (Ministry of Internal Affairs), Decree "On the establishment of the Working Group to implement the drug demand reduction and health protection program in the penal system of the Republic of Uzbekistan" [Приказ Главного управления исполнения наказаний МВД РУ «О создании Рабочей группы по реализации программы снижения спроса на наркотики и охраны здоровья в системе исполнения наказаний Республики Узбекистан»], Decree No. 13 (25 February 2005).

1336 *Penal Code of the Republic of Uzbekistan* [Уголовно-исполнительный кодекс], Law No. 409-1 (25 April 1997), Article 87 [hereinafter "*Penal Code*"].

1337 Ministry of Internal Affairs, "Internal regulations of penal institutions", [Правила внутреннего распорядка учреждений по исполнению наказания в виде лишения свободы], Order No. 118 (8 May 2001), para. 109.

1338 Ministry of Health and Ministry of Internal Affairs, Joint Resolution "On approval of the Regulations for registration and dispensary observation procedures for people with HIV and AIDS detained at pre-trial centres and penal institutions of the Ministry of Internal Affairs of the Republic of Uzbekistan" [Об утверждении инструкции о порядке учета и диспансерного наблюдения за ВИЧ-инфицированными и больными СПИДом, содержащимися в следственных изоляторах и учреждениях исполнения наказаний Министерства внутренних дел Республики Узбекистан],[hereinafter "Regulations on HIV-positive prisoners"].

1339 Ibid.

1340 "Regulations on HIV-positive prisoners".

informs the prisoner or detainee of an opportunity to undergo HIV counselling and testing voluntarily. The national expert group has noted that the wording of the "Internal regulations of penal institutions", which provides for "strict control over timely identification and treatment of people with HIV and AIDS at penal institutions", may be misinterpreted as encouraging or authorizing involuntary testing so as to identify HIV-positive persons.[1341]

Since January 2008, antiretroviral therapy to treat people with HIV has been introduced in the penal system of Uzbekistan.[1342] Prisoners with HIV are supposed to be provided with enhanced nutrition during treatment if indicated and, on the basis of medical certificate attesting to the need for enhanced nutrition, prisoners are also entitled to receive additional parcels from those outside prison.

HIV prevention in prisons

The national expert group has reported that a project of peer HIV education among prisoners is being implemented in Uzbekistan's prisons: prisoners are selected to be trained in HIV prevention methods and they in turn train other prisoners.[1343]

Uzbekistan's penal system does not currently implement HIV prevention activities such as condom distribution or harm reduction programmes to address risks associated with drug use.

Departmental documents of the penitentiary system do not prohibit the distribution and possession of condoms in prisons, but as noted above, the *Criminal Code* prohibits homosexual relations. This may be one factor impeding the implementation of condom distribution programmes among prisoners, since use of condoms may reveal details of prisoners' private sexual activity and expose them to criminal prosecution.

As of the end of 2008, the penal system in Uzbekistan did not have measures to ensure prisoners' access to sterile syringes. Prison regulations prohibit prisoners from possessing sharp cutting or piercing items,[1344] but prisoners are allowed to purchase and store disinfectants, including chloramine. Distribution of a disinfectant such as chloramine in the penal system is a useful intervention. However, as UN technical agencies have advised, it should not be considered an adequate alternative to ensuring access to sterile injection equipment.[1345] While laboratory studies have shown that bleach can eliminate HIV (but not hepatitis C virus), field studies have raised considerable doubt that this or other disinfectants can be effective in real-life conditions, since many people who inject drugs cannot or do not consistently practice proper methods for disinfecting syringes. The likelihood of effective decontamination is even lower among prisoners, since the circumstances of drug use in prison are even less conducive to careful, repeated cleansing of injection equipment: prisoners may not have the time to do so, given the risk of being caught using prohibited drugs, and may often be using makeshift equipment that is more difficult to decontaminate effectively using disinfectants. Consequently, UN technical agencies have characterized access to disinfectants only as a "sub-optimal" approach, and have concluded that access to sterile injection equipment is the most effective measure to prevent the transmission of HIV and other blood-borne diseases among those injecting drugs in prisons. To strengthen HIV prevention efforts in prisons, including among people who inject drugs, the national expert group has recommended allowing the possession of not only disinfectants, but also condoms and needles.

Compulsory treatment of drug dependence in prisons

Court-ordered compulsory treatment of prisoners with alcohol and drug dependence is carried out in specialized penal institutions with different types of security. As a general rule, persons subject to compulsory treatment for alcohol or drug dependence are detained separately from other prisoners.[1346] For this purpose people are housed in isolated living sections of specialised drug dependence treatment facilities. Treatment is provided by a narcologist in two stages: inpatient (for up to 2 months) and outpatient (for up to 2 years). Detoxification and the alleviation of withdrawal symptoms (using tranquilizers, nootropics and vitamins) are the main types of treatment; treatment is supervised by narcologists and general practitioners.

Prisoners may be released from work duties for purposes of testing and treatment in inpatient facilities of a medical unit or hospital; this includes prisoners undergoing compulsory treatment for alcohol or drug dependence. After a prisoner has completed a full course of treatment, the administration of the penal institution submits a report to the court with a request cancelling the treatment order.

According to prison regulations, rehabilitation prior to release from prison includes social rehabilitation in relation to drug use. Preparation of a prisoner for a release shall start not later than 3 months prior to release and includes activities aimed at helping arrange employment and housing outside of prison.[1347] A month before a prisoner is released the medical unit of the penal institution notifies the health authority responsible for the area in which the prisoner is registered as a resident, and provides a report on the results of the person's compulsory drug dependence treatment. If drug dependence treatment is not completed by the time of the prisoner's release, he or she is registered by territorial health authorities and compulsory treatment is continued in health facilities after release.[1348]

Transfers, absences and compassionate release from prison

Currently, the *Penal Code* discriminates against prisoners based on HIV status and drug dependence in several ways.

First, after serving a portion of a sentence, prisoners deemed to be of "good behaviour" may be eligible to transfer from a colony with a stricter security regime to other, less strict facilities. However, prisoners ordered to undergo compulsory treatment for drug dependence and prisoners with infectious diseases (including HIV) are not eligible for such a transfer.[1349] Second, in exceptional circumstances (e.g., death or illness of relatives) prisoners can be permitted a temporary absence from the institution, for up to 7 days (not counting travel time).[1350] However, people who are ordered to undergo compulsory drug dependence treatment, and prisoners with infectious diseases (including HIV), are not eligible for such a leave.[1351] Third, prisoners deemed to be of "good behaviour" may be permitted a temporary unescorted absence outside the penal institution, after serving not less that one-third or one-half of their term, depending on the circumstances. However, prisoners who are ordered to undergo compulsory treatment and prisoners with infectious diseases (including HIV) are not eligible for such a benefit.[1352] According to the national expert group, such discriminatory measures creates a disincentive for prisoners to seek voluntary HIV testing, given this additional negative consequence that follows if the prisoner tests positive.

If a prisoner is temporarily unable to work because of illness, he or she may be released from work and referred to treatment.[1353] In the case of a permanent or long-term disability that considerably limits capacity to work, a patient shall be given disability status, which legally entitles person to disability support, discounted medicine and other benefits.

Under the *Criminal Code*, a person who develops a serious illness that prevents him or her from serving out a custodial sentence shall be released.[1354] According to a joint order of the Ministries of Health and Internal Affairs, prisoners with certain specified diseases are eligible for release on a compassionate basis; prisoners with AIDS are included on this list.[1355]

1341 "Internal regulations of penal institutions", para. 74: 360.

1342 Joint Resolution of the Ministry of Internal Affairs (No. 19) and of the Ministry of Health of the Republic of Uzbekistan (No. 16), "On approval of the Regulations for provision of antiretroviral therapy to the HIV-infected and people with AIDS detained at pre-trial centres and penal institutions of the Ministry of Internal Affairs of the Republic of Uzbekistan" (27 November 2007).

1343 Information provided by the national expert group.

1344 "Internal regulations of penal institutions".

1345 World Health Organization, UNAIDS and UN Office on Drugs and Crime, *Interventions to Address HIV in Prisons: Needle and Syringe Programmes and Decontamination Strategies*, Evidence for Action Technical Papers (Geneva, 2007);

1346 "Internal regulations of penal institutions", para. 375 and 77; *Criminal Code*, Article 96.

1347 "Internal regulations of penal institutions", para. 387. Currently, in one of the country's regions, an NGO is implementing a pilot project aimed at social rehabilitation after release from prison, including narcotic drug use-related social rehabilitation.

1348 Ministry of Internal Affairs, Order "On approval of the Regulations for provision of health services to persons detained at penal institutions and pre-trial centres of the Ministry of Internal Affairs of the Republic of Uzbekistan", para. 327 [hereinafter "Regulations on health services"].

1349 *Penal Code*, Article 113.

1350 *Penal Code*, Article 82.

1351 Ibid.

1352 *Penal Code*, Article 83.

1353 "Regulations on health services", para. 443.

1354 *Criminal Code*, Article 75.

1355 Ministry of Internal Affairs and Ministry of Health, Joint Order "On nomination of prisoners for release due to illness" [О предоставлении осужденных на освобождение от наказание по болезни].

6. DISCRIMINATION AND RESTRICTION OF RIGHTS

Although Uzbekistan's Constitution does not define the concept of "discrimination", it does include a basic equality rights provision.[1356] The *Criminal Code* envisages criminal liability for violating the principle of equality.[1357] National legislation also has a number of provisions protecting against discrimination based on HIV status.

The *Law* "*On protection of public health*" contains special anti-discrimination provisions applicable in the context of health:

> Citizens of the Republic of Uzbekistan shall have an inherent right to health care. The state guarantees its citizens health care irrespective of age, gender, race, ethnicity, language, attitude towards religion, social background, views, personal and social status. The state guarantees its citizens protection against discrimination, despite the presence of any disease. Persons violating these provisions shall bear responsibility as established by the law.[1358]

Discrimination based on HIV status

The *Law "On HIV"* contains provisions specifically prohibiting the following forms of discrimination against people living with HIV and AIDS:

- termination of labour contracts;
- refusal to hire, except for certain professions (not specified in this law, but listed in a separate Government resolution); and
- refusal to admit a person to educational institutions or to health care facilities.[1359]

In addition, the *Law "On HIV"* prohibits limiting other rights and legitimate interests of people living with HIV and AIDS based on their status, as well as restrictions on housing and other rights and legitimate interests of their families.[1360]

Notwithstanding these provisions in the law, military conscripts who are HIV-positive are deemed unfit solely on this basis and hence subject to dismissal.[1361] In addition, some agencies and organizations have introduced their own rules mandating HIV testing in certain employment contexts (e.g., police officers; employees of the National Security Service; physicians, surgeons and gynecologists, dentists; food industry workers, people cleaning medical and cosmetic equipment, manufacture of medicine, care for newborns, child care). However, such practices amount to unjustifiable invasions of privacy and unjustifiable discrimination; it is incorrect to equate HIV-positive status with inability to perform such duties. The Government of Uzbekistan should abolish and prohibit such policies, in line with the stated principles of non-discrimination in Uzbek law (noted above) and international standards.[1362]

Discrimination based on drug use or dependence

The review by the national expert group also identified discrimination against people who use drugs as an area of concern, given the objective of strengthening HIV prevention and care among this vulnerable population. The expert group's analysis suggested that Uzbek legislation has provisions that need to be revised, primarily due to the fact that they might cause stigmatization of people who use drugs and people living with HIV/AIDS. Currently, Uzbek law does not contain any provisions protecting people who use or are dependent on drugs from discrimination. Yet, as in other countries in the region, in Uzbekistan such discrimination based on drug use exists. Examples include the following:

1356 Article 18 of the Constitution states that citizens of Uzbekistan have equal rights and freedoms, and are equal before the law, without distinction on the grounds of sex, race, ethnic origin, language, religion, birth, beliefs and personal or social position.

1357 *Criminal Code*, Article 141.

1358 *Law "On protection of public health"*, Article 13 [unofficial translation].

1359 Law "On HIV", Article 10.

1360 Ibid.

1361 Information provided by the national expert group.

1362 *International Guidelines on HIV/AIDS and Human Rights*, 2006 Consolidated Version, para. 22(a), (d), (j).

- *Discrimination in education or employment*: As a rule, if a student or employee is suspected of being under the influence of drugs, he or she is suspended from study or work and referred for compulsory drug testing in narcological facility.[1363] Being under the influence of drugs may be considered a breach of the employment contract or rules of the educational institution, leading to termination of employment or suspension. People who use drugs are also restricted from performing certain activities. There is a list of occupations prohibited for people with drug dependence: health care and pharmacy workers, pharmaceutical industry, veterinarians, jobs connected with manufacturing, storage and sale of food and water, jobs connected with water supply, hydroelectrical jobs and artificial water bodies.[1364] Refusal to undergo drug testing is an administrative offence for drivers.[1365]

- *Discrimination in family relations*: Persons who are registered as drug users or people with drug dependence cannot become adoptive parents.[1366] In cases of concern about child abuse or neglect, people with drug dependence *per se* may suffice as a basis for depriving someone of his or her parental rights.[1367]

According to principles well established in international human rights law, limitations or infringements on human rights may only be justified in accordance with clear standards.[1368] One key principle is that of non-discrimination, including based on health status. Indeed, as noted above, Uzbekistan's own *Law "On protection of public health"* (Article 13) declares that: "The state guarantees its citizens protection against discrimination no matter what diseases they may have." This should include drug dependence. It will be the very rare case in which denying certain rights or benefits to entire classes of persons based on their health status (e.g., diagnosis of HIV infection or drug dependence) will be justifiable. Rather, discriminating in education or employment or denying parental rights should require case-by-case justifications, based on an assessment of individual circumstances, rather than based on inaccurate, generalized assumptions about a person's capacity to study, work or be a suitable parent based on health status.

1363 For example, as noted above, a person may be subjected to compulsory drug testing by police if there are "sufficient reasons" to believe the person is drug dependent or intoxicated or has used drugs without prescription: *Law "On narcotic drugs and psychoactive substances"*, Article 35.

1364 Ministry of Health, Ministry of Labour and Social Protection, and Trade Union Federation Council, Resolution "On establishing a list of professional activities restricted for people with drug dependence" [Об утверждении перечня видов профессиональной деятельности, на занятие которыми установлены ограничения для лиц, страдающих наркоманией], Resolution No. 8/46/14-10 (7 April 2003). Ministry of Health, Ministry of Internal Affairs and Ministry of Justice, Instruction "On the procedure of referring persons operating means of transportation for testing to determine use of alcoholic and other intoxicating substances and on testing" [Инструкция О порядке направления лиц, управляющих транспортными средствами на освидетельствование для установления факта употребления алкогольных или других одурманивающих веществ и проведения освидетельствования], No. 5/01-1/37/5/224 (18 April 1992).

1365 *Administrative Code*, Article 136.

1366 *Family Code*, Article 152.

1367 *Family Code*, Law No 607 (30 April 1998), Article 79.

1368 UN Economic and Social Council, *Siracusa Principles on the Limitation and Derogation Provisions in the International Covenant on Civil and Political Rights*, UN Doc. E/CN.4/1985/4, Annex (1985).

7. RECOMMENDATIONS FOR LEGISLATIVE AND POLICY REFORM

After completing its review of legislation and practices in Uzbekistan, the national expert group has noted that the national legislation has many declarative provisions regarding HIV prevention and treatment which are not implemented in practice. In addition, the national expert group has emphasized that the national approach to high-risk groups such as people who use drugs and prisoners is still largely based on enforcement of criminal and administrative legal prohibitions, rather than healthcare interventions; this approach impedes HIV prevention and treatment among such groups.

The national expert group has also concluded that current provisions of the *Law "On HIV"* are inadequate to protect the rights and legal interests of people living with HIV and in some instances contributes to HIV-related stigma; in addition, it does not include some provisions that are needed or advisable to support effective HIV prevention and treatment measures, particularly among some vulnerable populations. Particular areas of concern include such things as ensuring proper counselling and confidentiality protections accompanying HIV testing, unjustifiable procedures of mandatory testing, and discriminatory treatment of non-citizens who are HIV-positive. These recommended amendments to the *Law "On HIV"* from the national expert group are reflected in a number of the recommendations below.

The recommendations presented here are aimed at addressing issues identified by the national expert group of Uzbekistan and by the project's technical advisors. Suggested language of legislative amendments is shown in shaded boxes.[1369]

Administrative and criminal law issues

Recommendation 1: Remove penalties on possession of small quantities of drugs without intention to sell

As noted above, under the *Administrative Code* (Article 56), possession of drugs without an intention to sell is an administrative offence, punishable by a fine, in the case of "small" [небольшие] quantities (e.g., less than 0.01g in the case of cocaine). In the case of heroin, there are no "small" quantities according to current Uzbek law: even 0.001-0.005g of heroin is considered to be "exceeding small" [превышающие небольшие] quantities, which leads to criminal liability. In this regard, Uzbek law is one of the most punitive in the region. It imposes very harsh penalties for possession of miniscule amounts of drugs, *even where there is no intent to sell*. Given the nature of drug dependence as a chronic, relapsing condition, criminalizing repeated possession of small and minor quantities of a prohibited drug, even without intention to sell, criminalizes people with drug dependence. The Government of Uzbekistan should consider entirely removing criminal penalties for possession of "small" [небольшие] and "exceeding small" [превышающие небольшие] quantities where there is no intention to sell.[1370] This could be achieved by enacting a provision such as the following in the *Criminal Code* (and in the *Administrative Code* as well, should the decision be made to remove administrative penalties as well for possession of such quantities without intention to sell):[1371]

Decriminalization [or depenalization] of possession without intention to sell

> Notwithstanding anything in the *Criminal Code of the Republic of Uzbekistan* [and/or the *Code of the Republic of Uzbekistan on Administrative Liability*], the use and possession of a controlled substance in a small [небольшие] or exceeding small [превышающие небольшие] quantity with no intention to sell does not attract a criminal penalty [nor does it attract an administrative penalty].

1369 In many instances, the wording of proposed legislative amendments is adapted from model provisions in Legislating for Health and Human Rights: Model Law on Drug Use and HIV/AIDS (Toronto: Canadian HIV/AIDS Legal Network, 2006), online in both English (www.aidslaw.ca/modellaw) and Russian (www.aidslaw.ca/modellaw-ru). This publication, consisting of a series of 8 modules on different issues, was used as a key reference by UNODC, national expert groups and the project's technical advisors during the review and assessment of national legislation in the countries participating in the project. Where relevant, citations below are to specific modules of that resource; the accompanying text and commentary to be found in those modules may be useful to legislators and policy-makers in implementing these recommendations.

1370 See *Legislating for Health and Human Rights: Model Law on Drug Use and HIV/AIDS*, Module 1: Criminal law issues, pp. 18-21.

1371 See *Legislating for Health and Human Rights: Model Law on Drug Use and HIV/AIDS*, Module 1: Criminal law issues, pp. 18-21.

Recommendation 2: Revise current amounts of narcotic drugs in order to depenalize possession of limited quantities with no intention of sale

As noted above, Uzbekistan's definition of what constitutes "small" [небольшие] or "exceeding small" [превышающие небольшие] quantities of some narcotic drugs and psychotropic substances is particularly draconian, with the effect of criminalizing and administratively penalizing people who possess even quite limited quantities of drugs because of their drug dependence. Recommendation 1 above is aimed at removing criminal and administrative liability for possession of "small" and "exceeding" small quantities of drugs *without an intention to sell*. However, simply amending the law to state this is insufficient if the actual quantities defined as "small" and "exceeding small" remain very restrictive. Therefore, in conjunction with Recommendation 1, the Government of Uzbekistan should also review the current definitions with a view to liberalizing them and avoiding this unnecessarily strict, and counterproductive, penalization of people with drug dependence. Specifically, it should revise Article 274 of the *Criminal Code* and Article 190 of the *Administrative Code* (and the corresponding schedules) to redefine the "small" [небольшие] and "exceeding small" [превышающие небольшие] amounts of narcotic drugs and psychotropic substances, so that drug-dependent persons could possess quantities for personal use without fear of criminal or administrative prosecution, in order to preclude the unproductive conflict of the law enforcement with people who use drugs.

Recommendation 3: In qualifying an offence related to drugs, take into account pure amount of narcotic drug (without fillers)

Current drug Schedules in Uzbekistan define quantities of drugs "irrespective of (any) fillers". According to the information presented by the expert group, in practice, this means that law enforcement expertise counts the entire amount of the mixture. Taking into account that the amount of the drug influences liability and often administrative or criminal charges, it is recommended to delete the words "irrespective of (any) fillers) from the Schedules. Defining various quantity ranges of different drugs, the law should make clear that this is a reference to a quantity of the pure drug itself, not the quantity that includes other fillers or additives that may be mixed with it.

Recommendation 4: Remove intoxication as aggravating factor for criminal liability

According to the *Criminal Code* (Article 56), being intoxicated by drugs or alcohol while committing a crime is an aggravating circumstance. However, whether or not a person is intoxicated does not affect the gravity of the harm of his or her crime, so it should not be considered as making the crime more serious. Rather, such a provision effectively discriminates against people accused of crimes based on their health status (i.e., dependence of drugs or alcohol), imposing harsher penalties for a given crime on people with this health condition. Article 56 should be repealed.

Recommendation 5: Create a clear legislative framework for harm reduction measures, including needle and syringe programmes

With the objective of supporting effective HIV prevention among injection drug users (including those in penal institutions), and protecting the public health more generally, the national expert group has recommended creating a clear legislative framework for harm reduction measures, including needle and syringe programmes (and including the disposal of used syringes). Wording of legislative provisions such as the following could be introduced to the existing *Law "On HIV"* or other suitable legislation:[1372]

Sterile syringe programmes

> 1. "Sterile syringe programme" means a programme that provides access to sterile syringes and other related material, information on HIV transmission and other blood-borne pathogens, or re-

1372 See Legislating for Health and Human Rights: Model Law on Drug Use and HIV/AIDS, Module 3: Sterile syringe programs, pp. 12-13.

ferrals to substance abuse treatment services. It includes needle exchange programmes, needle distribution programmes and other forms of sterile syringe distribution.

2. Staff of the sterile syringe programme may provide a range of material and services, including the following:
a) sterile syringes and other related material for safer injection drug use, including sterile water ampoules, swabs, filters, safe acid preparations, spoons and bowls and other appropriate materials;
b) material to enable safer smoking and inhalation of drugs, such as pipes, stems, metal screens, alcohol wipes and lip balm;
c) condoms and other safer sex materials, such as water-based lubricants and dental dams, as well as information about reducing the risks of HIV and other sexually transmitted infections; and
d) first aid in emergency situations.

3. Staff of sterile syringe programmes may provide information including, but not limited to, the following:
a) drug dependence treatment services and other health services;
b) means of protection against transmissible diseases, including blood-borne diseases such as HIV;
c) the risks associated with the use of controlled substances;
d) harm reduction information specific to the drug being used, including safe injecting and inhaling practices;
e) legal aid services;
f) employment and vocational training services and centres; and
g) available support services for people with drug dependence and their families.

4. The state shall ensure access to sterile syringes for people who require them. Where sterile syringes are not otherwise available and there is demand, the state shall establish a sterile syringe programme out of public funds. The state may distribute sterile syringes through public health facilities or provide funding to community organizations to operate sterile syringe programmes.

Recommendation 6: Preclude criminal or administrative liability for harm reduction programmes

The harm reduction and outreach activities of non-governmental organizations targeting people who use drugs, such as programmes providing sterile syringes or other equipment to reduce harms associated with drug use (including HIV transmission), should be clearly exempt from possible liability. In particular, they should be exempt from liability under Article 274 ("involvement in drug use") of the *Criminal Code* for their harm reduction activities, including distribution of injection equipment. Similarly, they should be exempt from liability under Article 56 of the *Administrative Code* for "possession" of residual quantities of drugs in used injection or other equipment or Article 276 of the *Criminal Code* (possession without intention to sell). Similarly, Article 36 of the *Law "On narcotic drugs and psychotropic substances"* (which prohibits "propaganda" of drug use) should also include a provision exempting harm reduction programmes from liability.

Specific legislative provisions such as the following could achieve this objective of protecting harm reduction programmes and their staff and volunteers from legal liability:[1373]

Exemption from criminal liability for sterile syringe and other harm reduction programmes

Nothing in the *Criminal Code, the Administrative Code* or other law prevents the supply of sterile syringes and other related material, or the giving of advice, information or instruction on the safe use of syringes and other related material, by staff of a sterile syringe programme or other programme aimed at reducing harms associated with the use of prohibited narcotics or psychotropic substances. For greater clarity, any prohibition in the *Criminal Code* or other law on "involvement in drug use" does not apply to providing equipment and information on drug use for the purpose of preventing the spread of HIV and other blood-borne infections or other injuries or harms that may be associated with drug use.

No penalty for possession of residual amounts of substances in drug use equipment

A person who is in possession of any residual amount of a prohibited narcotic or psychotropic substance that is contained in or on a syringe or other equipment used to ingest such a substance does not, by the mere fact of that possession, commit an offence under any law.

Recommendation 7: Eliminate or narrow the use of compulsory drug testing

Currently, Article 35 of the *Law "On narcotic drugs and psychotropic substances"*, authorizes compulsory drug testing if there are "sufficient grounds to believe" [достаточные основания полагать] that a person (a) has consumed illegal drugs, (b) is under the influence of alcohol or narcotics, or (c) has used a narcotic or psychotropic substance without a prescription from a medical doctor. As outlined above, such broad provisions unjustifiably infringe numerous human rights. Among other things, compulsory drug testing violates privacy and security of the person, without justification in most circumstances, since merely showing past use of drugs does not prove there is a risk of harm to self or others, which should be the only basis for possibly justifying an intrusion by the state into such rights. To eliminate unjustifiably broad provisions for compulsory drug testing, Article 35 of the *Law "On narcotic drugs and psychotropic substances"* should be repealed.

Recommendation 8: Decriminalize homosexual relations

The *International Guidelines on HIV/AIDS and Human Rights* (Guideline 5) recommend repealing laws that criminalize consensual sexual relations between adults of the same sex, since such laws violate human rights to liberty, security of the person, privacy and non-discrimination. Criminalizing men who have sex with men also undermines effective HIV prevention among this vulnerable populations and access to health services. Therefore, it is recommended that the Government of Uzbekistan repeal Article 120 of the *Criminal Code*.[1374]

Recommendation 9 Eliminate HIV-specific criminal law

Article 113 of the *Criminal Code*, which specifically provides for punishment for transmission and exposure to "venereal infections" and "AIDS disease", should be repealed. In the case of intentional transmission of venereal or HIV infection, this could be dealt with as infliction of bodily harm that is covered by Articles 104-111 of the *Criminal Code*.

Recommendation 10: Decriminalize sex workers

It is recommended to repeal Article 190 of the *Administrative Code* (sex work) and Article 131 of the *Criminal Code* (organising brothels). The *International Guidelines on HIV/AIDS and Human Rights* recommend that with regard to adult sex work that involves no victimization, criminal law should be reviewed with the aim of decriminalising and legally regulating occupational health and safety conditions to protect sex workers and their clients, including support for safe sex during sex work.[1375] The criminal prohibition on recruiting people for sexual or other exploitation (Article 135 of the *Criminal Code*) and other existing criminal law provisions to deal with assault and coercion are sufficient for addressing human trafficking and exploitation, human rights abuses which require attention.

1373 See *Legislating for Health and Human Rights: Model Law on Drug Use and HIV/AIDS*, Module 3: Sterile syringe programs, pp. 19-21.

1374 Cases where sex between men is non-consensual should be covered under Articles 118-119 of the *Criminal Code* the same way as other cases of sexual assault.

1375 *International Guidelines on HIV/AIDS and Human Rights* (Guideline 4, para. 21(c)).

Drug dependence treatment

Recommendation 11: Amend the law on drugs to add provisions on drug dependence treatment or adopt a new law on drug dependence treatment

The current *Law "On narcotic drugs and psychotropic substances"* has only three articles regulating provision of drug dependence treatment. The national expert group has noted that, in light of Uzbekistan's growing public health problem of drug dependence, there is a need to strengthen the legislative framework supporting effective drug dependence treatment; it has recommended the adoption of a new law for this purpose. According to the report of the national expert group, the Ministry of Health has tabled a draft of such a new law. To strengthen HIV prevention and treatment efforts among the vulnerable population of people who use drugs, this new law should have at least the following features:

- The law should include provisions for substitution therapy and harm reduction programmes, including in prisons and other custodial settings. (For more on prisons, see Recommendation 26 below.)
- The law should include provisions protecting patients' rights in the context of drug dependence treatment, including ensuring access to voluntary treatment. Furthermore, at most compulsory treatment should be limited to urgent cases only as specified by the law and with safeguards to protect against unjustifiable compulsion. (For more on this point, see Recommendation 11 below.)
- The law should have strong provisions addressing discrimination against people living with HIV and people who use drugs.
- The law should elaborate some outreach activities in detail to ensure clear legal support of such activities.

Sample legislative provisions on several of these points have been prepared and could be adapted to the Uzbek national context.[1376]

Recommendation 12: Limiting compulsory drug dependence treatment

It is recommended that the *Law on compulsory treatment of people with alcoholism and drug dependence* should be repealed so as to abolish the possibility of compulsory treatment of drug dependence being applied to any person. In addition, Article 44 (paragraph 4) of the *Law "On narcotic drugs and psychotropic substances"*, which mentions compulsory treatment, should be struck out. As noted above, involuntary medical interventions are, absent some very clear and strong justification, a violation of basic human rights recognized in international law. At most, compulsory treatment for persons who are confirmed to be drug dependent (and not simply casual drug users) can only be justified as a last resort, in exceptional circumstances.

It is further recommended that, if compulsory drug dependence treatment remains in place in Uzbek law as a feature of the criminal justice system, notwithstanding the above recommendations, the *Criminal Code* should be amended to allow such drug dependence treatment to be an *alternative* to conviction and imprisonment in at least some cases of drug offences, rather than an *additional* part of the sentence on top of penal sanctions. As described above, this would be in conformity with the international drug control treaties.

Recommendation 13: Reinstate opioid substitution treatment programmes

Opioid substitution treatment is one critically important component of drug dependence treatment, and recognized in international best practice as key to HIV prevention among people who inject drugs. Uzbekistan became one of the very few countries which abolished this efficient and scientifically proven intervention. The Government of Uzbekistan is recommended to reinstate OST and scale up programmes. Methods of drug dependence treatment need to be expanded and brought in line with international standards and good practice. In order to strengthen the legal basis for programmes of opioid substitution therapy, the national expert group has recommended adding several articles on OST into the *Law on narcotic drugs and psychotropic substances*, and in a new law on drug dependence treatment (as noted in Recommendation 9 above).[1377] For effective implementation of OST programmes, it is recommended to add medications such as methadone and buprenorphine to the list of essential drugs, reflecting a classification already made by the WHO, and to move methadone onto the list of drugs whose distribution is allowed to a limited degree (which list already includes buprenorphine).

Recommendation 14: Ensure patient confidentiality

The national expert group has noted that medical facilities report information about persons who are registered to law enforcement agencies, including cases in which people seek overdose treatment, which is at odds with the principle of confidentiality.[1378] As the expert group has pointed out, routine disclosure of such personal information, including health information, to law enforcement bodies not only infringes human rights but also undermines patients' trust in medical workers and creates a barrier to seeking medical services, including treatment for drug dependence. The Ministries of Health and Internal Affairs should amend their joint order to repeal the sections that allow or require this sharing of confidential health information with law enforcement, and should instead prohibit health agencies from sharing such information about persons who use drugs with law enforcement agencies. Specifically, the law should be amended so as to permit (but not require) health professionals of such narcological centres to breach patient confidentiality only in circumstances where health professionals believe, in good faith and on reasonable grounds, that doing so is necessary to prevent imminent, serious harm to a patient or to another person. Additionally, health professionals should be required to share confidential information with law enforcement bodies only following a court order. All other instances of sharing information should be prohibited.

In addition, the *Law "On narcotic drugs and psychotropic substances"* and any new law on drug dependence treatment should also be amended to include explicit provisions strengthening the confidentiality of health information of patients receiving narcological assistance. Provisions such as the following should be added to the legislation:[1379]

> (1) The confidentiality of all health care information shall be respected. Records of the identity, diagnosis, prognosis or treatment of any patient which are created or obtained in the course of drug dependence treatment:
>
> a) are confidential;
>
> b) are not open to public inspection or disclosure;
>
> c) shall not be shared with other individuals or agencies without the consent of the person to whom the record relates; and
>
> d) shall not be discoverable or admissible during legal proceedings.
>
> (2) No record referred to in Section (1) may be used to
>
> a) initiate or substantiate any criminal charges against a patient; or
>
> b) act as grounds for conducting any investigation of a patient.
>
> (3) Programme staff cannot be compelled under any other law to provide evidence concerning the information that was entrusted to them or became known to them in this capacity.
>
> (4) All use of personal information of patients and programme staff in research and evaluation shall be undertaken in conditions guaranteeing anonymity, and any such information shall also be governed by Section (2) of this article.

1376 See Legislating for Health and Human Rights: Model Law on Drug Use and HIV/AIDS, and in particular Module 2: Treatment for drug dependence, Module 6: Outreach and information, and Module 7: Stigma and discrimination.

1377 For model provisions that could be usefully incorporated into law to support OST programs that reflect human rights principles, see *Legislating for Health and Human Rights: Model Law on Drug Use and HIV/AIDS*, Module 2: Treatment for drug dependence, pp. 25-33.

1378 This sharing of patient information is based on a joint order from the Ministries of Internal Affairs and Health: Joint Order "On Approving the Instruction for the Procedure of Organizing Prevention Activities of Internal Affairs and Health Care Agencies with Persons Abusing Alcoholic Drinks or Narcotic Substances and Referrals to Obligatory Treatment of People with Chronic Alcoholism and Drug Dependence" [Об утверждении инструкции о порядке организации профилактической работы органов внутренних дел и здравоохранения с лицами, злоупотребляющими спиртными напитками или наркотическими средствами, и направления на принудительное лечение больных хроническим алкоголизмом или наркоманией], Order No. 326/599 (27 December 1994).

1379 See *Legislating for Health and Human Rights: Model Law on Drug Use and HIV/AIDS*, Module 2: Treatment for drug dependence, pp. 20-22.

Recommendation 15: Review, reform and perhaps abolish drug user registration

According to the national expert group's assessment of the available evidence, the current system of drug user registration in Uzbekistan does not work, promotes human rights violations and police corruption, and impedes people's access to drug dependence treatment (thereby undermining HIV prevention efforts among people who use drugs). Therefore, the Government of Uzbekistan should assess the effectiveness, efficiency, and economic benefit of this measure, with a view to reforming the current system, and possibly even abolishing it.

In order to protect and respect human rights, and to remove a reason for people to avoid seeking treatment for drug dependence or help with problematic drug use, Uzbekistan should abolish a central registry of people who use drugs and are dependent on it, which registry is then used in ways that can infringe human rights. To this end, Article 46 of the *Law "On narcotic drugs and psychotropic substances"* should be amended to repeal the provision on registration of people who use drugs; the relevant regulations that implement such a registry should also be amended. (Obviously, centres providing drug dependence treatment need to maintain some individualized information about patients in order to deliver treatment properly, and can and should continue to do so, as health facilities do with other patients receiving other kinds of health services, with proper protections for the confidentiality of patients' health information.)

Recommendation 16: Expand measures used to treat overdoses

In 2009, naloxone was included in the list of essential medicines in Uzbekistan. This is a welcome development, which complies with international health care recommendations. In addition, in order to prevent deaths and other serious harms from overdoses among opioid users, outreach workers (including those working for non-governmental organizations and including "peers" who are themselves persons who use or have previously used drugs), should be given the legal right to distribute and administer medications such as naloxone in cases of overdose. This could be done by introducing provisions such as the following into the *Law "On narcotic drugs and psychotropic substances"* and/or a new law on drug treatment:[1380]

Outreach to people who use drugs

(1) "Outreach work" means a community-oriented activity undertaken to contact and provide information and services to individuals or groups from particular populations at risk of blood-borne diseases, particularly those who are not effectively contacted or reached by existing information and services or through traditional health care channels.

(2) "Outreach workers" include paid social or public health workers or unpaid volunteers (including peers) of governmental or non-governmental facilities.

(3) Outreach workers may include people who currently use drugs, people who formerly used drugs or people who do not use drugs and are trusted by people who use drugs.

Administration of an opioid antagonist

(1) The Ministry of Health must make provision for the appropriate training of outreach workers in the administration of opioid antagonists.

(2) An outreach worker may administer an opioid antagonist to another person if:
a) the worker believes, in good faith, that the other person is experiencing a drug overdose; and
b) the worker acts with reasonable care in administering the drug to the other person.

(3) An outreach worker who administers an opioid antagonist to another person pursuant to Section (1) shall not be subject to civil liability or criminal prosecution as a result of the administration of the opioid antagonist.

1380 See *Legislating for Health and Human Rights: Model Law on Drug Use and HIV/AIDS*, Module 6: Outreach and information, pp. 14-15.

Taking into account incident of drug use in prisons, in order to preclude overdose complications in prisons, it is recommended to allow peer educators among prisoners and prison staff to administer naloxone in case of overdose in penitentiary institutions, and train them to use this emergency response medication.

HIV testing and treatment

Recommendation 17: Introduce HIV prevention for people who use drugs in the HIV law

Given the significant role of injecting drug use in the HIV epidemic in Uzbekistan, it is important that the *Law "On HIV"* reflect and support measures to prevent HIV and other harms to which people who use drugs are vulnerable, in accordance with international standards and recognized good practice. To this end, the *Law "On HIV"* should be strengthened by legislatively mandating harm reduction measures for people who use drugs and prisoners. This should include directives specifically to government bodies and agencies that have particular responsibilities in this area, such as the Ministry of Health and Ministry of Justice, as well as clearly directing law enforcement bodies (e.g., National Information and Analytical Centre for Drug Control) to cooperate with other government bodies and with non-governmental organizations to ensure the effective delivery and operation of harm reduction services (e.g., sterile syringe programmes, OST).

Recommendation 18: Remove stigmatizing and unwarranted classification of HIV as dangerous disease. Discuss abolition of the lists of "socially significant diseases" and "diseases that pose threat to others".

Currently, the *Law "On HIV"* (Article 2) classifies HIV infection as "socially significant" and as a "disease that poses threat to others", which classifications underlies the practice of mandatory testing upon the order of the Ministry of Health. While HIV infection is a serious disease, it is not casually communicable; it can only be transmitted through certain known exposures to bodily fluids. However, this classification of HIV may reinforce inaccurate fears about the transmissibility of HIV and thereby encourage increased stigma and discrimination against people living with HIV or perceived to be HIV-positive. Such stigma creates a further disincentive for people to seek HIV testing and to disclose their HIV-positive status if diagnosed positive, which impedes efforts to prevent and treat HIV. Therefore, it is recommended that legislators discuss the possibility of abolishing these lists as inducing stigma.

Recommendation 19: Ensure informed consent to HIV testing

The national expert group has reported that welcome steps are being taken to ensure a clear legal requirement to ensure people give consent to HIV testing that meets the requirements of informed consent, and that testing be accompanied by pre- and post-test counselling. While the details could be set out in different instruments (e.g., a regulation or order from the Ministry of Health), it would also be advisable to include in the *Law "On HIV"* provisions along the lines of the following:

> No test for HIV or other blood-borne infection shall be undertaken except with the informed voluntary consent of the person being tested, which informed consent should be clearly documented in writing. All such testing must be accompanied by pre- and post-test counselling, in accordance with professional standards, as part of ensuring informed consent on the part of the person being tested.

Recommendation 20: Improve blood safety and quality of HIV testing of blood donors

The national expert group has recommended reviewing legal and regulatory acts to ensure the safety of donated blood and its components, and to introduce requirements for pre-test and post-test counselling of blood donors and the confidentiality of test results, in conformity with international standards.

Recommendation 21: Abolish or narrow mandatory HIV testing

Contrary to human rights principles and international guidelines, current Uzbek law authorizes mandatory or compulsory testing of numerous groups or in specific situations. The national expert group and/or the project's technical advisors recommend a number of amendments in this area:

- Mandatory HIV testing for military recruits or personnel, or as a condition of admission or continued enrolment in academic institutions for military professions, is unjustifiable, and should be abolished, in accordance with international standards.[1381]
- Similarly, the Government should repeal the provisions mandating premarital testing for HIV, STIs, drug and alcohol dependence or psychological disorders.[1382]
- The Government should abolish the requirement that foreigners must prove HIV-negative status to obtain a visa to enter Uzbekistan (Article 12 of the *Law "On HIV")*; such a provision is a discriminatory and unjustified infringement on the right to free movement based on health status. The national expert group has also recommended that the provisions on deporting foreigners who test HIV-positive (Article 6 of the *Law "On HIV"*) be amended — specifically, by adding the limit that: "Foreign nationals and other non-citizens who are HIV-positive may be deported from Uzbekistan only in those cases when it is proved that they have infected other persons." Even better would be to simply delete Article 6 altogether, and not single out HIV for this specific, discriminatory treatment. Instead, general provisions in Uzbek law about when non-citizens may be deported for criminal activity should be applied where justified in a given case.
- Regulations compelling HIV testing of people who are identified as sexual contacts of persons living with HIV should be repealed.[1383] Such forced HIV testing, based merely on being identified as a past sexual contact, is an unjustifiable violation of bodily integrity, liberty and privacy.
- Compulsory HIV testing upon police request should be abolished.[1384] This, too, is an unjustifiable violation of bodily integrity, liberty and privacy.

Recommendation 22: Repeal administrative liability for avoiding testing and treatment

The *Administrative Code* (Articles 57 and 58) make it an administrative offence for a person to avoid testing and treatment for HIV or STIs if there is "sufficient information" [достаточные данные] to believe he or she is infected; they also make it an offence for a person to refuse to disclose the source of his or her infection with HIV or another STI. These provisions are overly broad, essentially imposing compulsory testing and treatment, upon pain of penalty, even when there is no imminent risk of harm to others and even when a person is fully competent to make his or her own decisions about whether to seek testing or treatment. The infringement on personal privacy, bodily integrity and potentially liberty (if a penalty were imposed) is disproportionate and not shown to be necessary. Intervening to compel testing or treatment may only be potentially justifiable in exceptional circumstances when an independent authority, based on appropriate and adequate evidence, determines that intervention is necessary to prevent a significant, imminent risk of harm to other identifiable person or persons, or in cases where the person himself or herself is not competent to make an informed decision about whether or not to seek testing or treatment. Even where intervention to impose testing or treatment may possibly be justified, the objective should be to protect the individual or others from harm, not to impose penalties. These provisions should be repealed; other measures in law to authorize coercive intervention in exceptional circumstances, with appropriate safeguards, are a preferable approach.

Recommendation 23: Strengthen patient rights

While the *Law "On protection of public health"* currently recognizes some important rights of patients, it should be strengthened — to the benefit of all patients, and not just those with HIV, STIs or drug dependence — by explicitly adding provisions such as the following to Article 31:[1385]

> Every patient has the right:
>
> a) to treatment and provided in accordance with good clinical practice;
> b) to treatment without discrimination;
> c) to meaningful participation in determining his or her own treatment goals;
> d) to meaningful participation in all treatment decisions, including when and how treatment is initiated and withdrawal from treatment;
> aa) to exercise his or her rights as a patient;
> ab) to confidentiality of medical records and clinical test results; and
> ac) to be fully informed, including but not limited to the right to receive information about:
> i) his or her state of health;
> ii) his or her rights and obligations as a patient, as specified in any applicable law;
> iii) the procedure for making a complaint about health services received; and
> iv) cost and payment conditions and the availability of medical insurance and other possible subsidies.
> ad) to decline treatment and testing

Furthermore, The expert group from Uzbekistan recommends, in order to enhance guarantees of protection of patient's rights, to draft and adopt a Law "On health care and patients' rights" , which would include fundamental international standards of patients' rights, including confidentiality and privacy.

Prisons

Recommendation 24: Ensure access to voluntary drug dependence treatment, including OST in prisons

Given the high prevalence of drug dependence among those imprisoned, the significance of risky drug use practices in contributing to the HIV epidemic, and the importance of providing access to health services that respect human rights and help promote the highest attainable standard of health for all persons, it is recommended that Uzbekistan implement voluntary drug dependence treatment programmes in prisons. As OST is made available outside prisons, it should similarly be made available inside prisons as one important element of programmes for addressing drug dependence. To this end, if amendments are introduced to the *Law "On narcotic drugs and psychotropic substances"* and/or a new law on drug dependence treatment is adopted, so as to create a clear legal framework for substitution therapy that protects and promotes the human rights of patients receiving OST (as suggested above in Recommendations 10 and 12), those amendments should include explicit reference to providing access to OST to drug-dependent persons in prisons. Such a provision could be worded as follows (and could also be inserted into legislation such as the *Penal Code*):[1386]

> **Opioid substitution treatment programmes in prison**
>
> (1) The Ministry of Health, with the support and cooperation of the Ministry of Justice, shall establish opioid substitution treatment programmes in all prisons.
>
> (2) Prisoners with opioid dependence shall be eligible for opioid substitution treatment in accordance with opioid substitution treatment guidelines applicable in the community.
>
> (3) Opioid substitution treatment shall be available for free on imprisonment and throughout the duration of imprisonment.

1381 *International Guidelines on HIV/AIDS and Human Rights*, 2006 Consolidated Version, para. 22(a), (d), (j).

1382 Regulation "On Medical Testing of Persons Planning to Marry" [О медицинском обследовании лиц, вступающих в брак], Regulation No. 365, Annex 1 to the Resolution of the Cabinet of Ministers, "On Approving the Provision of Medical Testing of Persons Planning to Marry" (25 August 2003).

1383 Sanitary Rules.

1384 Ibid, para. 13.

1385 See *Legislating for Health and Human Rights: Model Law on Drug Use and HIV/AIDS*, Module 2: Treatment for drug dependence, pp. 18-19.

1386 See *Legislating for Health and Human Rights: Model Law on Drug Use and HIV/AIDS*, Module 5: Prisons, pp. 30-32.

(4) Opioid substitution treatment shall not be restricted to those on a course of opioid substitution treatment prior to imprisonment; all prisoners shall be entitled, if eligible, to being on opioid substitution treatment while incarcerated.

(5) Participation in the opioid substitution treatment programmes shall be offered on a voluntary basis to all prisoners with opioid dependence.

(6) Opioid substitution treatment programmes may include a variety of approaches, including maintenance treatment.

(7) The programme shall ensure that staff members, prison officers, policy makers and prisoners have factual information regarding opioid substitution treatment.

(8) The programme shall develop a comprehensive discharge planning system for prisoners nearing release, including a system for referral to opioid substitution treatment programmes in the general community.

Recommendation 25: Strengthen HIV prevention in prisons and detention facilities

In order to strengthen HIV prevention efforts in prisons and pre-trial detention facilities, in addition to making OST available to opioid-dependent prisoners, legislative amendments could mandate the introduction of harm reduction programmes in prisons. The Internal Regulations of penitentiary institutions should be revised to strengthen HIV prevention among prisoners. This would include removing the Internal Regulations' provisions prohibiting prisoners from possessing needles and syringes, and inserting provisions that mandate access to bleach and sterile syringes, as well as ensuring access to condoms, and information related to risks of HIV transmission through unsafe sex or drug use. Provisions such as the following could be inserted into the Internal Regulations, the *Law "On HIV"* and/or the *Penal Code*, as deemed appropriate:[1387]

Distribution and possession of condoms and other safer sex materials in prisons

(1) The Ministry of Health and the Ministry of Internal Affairs shall ensure that condoms and other safer sex materials, along with appropriate information on their proper use and on their importance in preventing the spread of HIV infection and other sexually transmitted infections, are made available and easily accessible to prisoners in a manner that protects their anonymity.

(2) The Ministry of Health shall develop a plan for the disposal of used condoms that protects the anonymity of prisoners and the health of prison officers.

(3) The distribution and possession of condoms and other safer sex materials in prisons in accordance with this law shall not constitute a criminal nor administrative offence, nor are condoms and other safer sex materials admissible as evidence of sexual relations for the purposes of determining any criminal or administrative offence.

Authorization of harm reduction programmes

(1) Harm reduction programmes shall be implemented in all prisons according to the provisions set out herein, with the objective of reducing harms associated with unsafe use of drugs, including the risk of transmission of HIV or other blood-borne diseases.

(2) In order to prevent the spread of blood-borne diseases and minimize the health risks associated with drug use by prisoners, either the Ministry of Health or a local prison authority may authorize a specified person or organization (including non-governmental organisations) to deliver harm reduction programmes, including measures to supply sterile syringes and other related material to prisoners, as well as condoms and other materials to reduce the risks of HIV and other sexually transmitted infections.

1387 See *Legislating for Health and Human Rights: Model Law on Drug Use and HIV/AIDS*, Module 5: Prisons, pp. 25-30.

Information

Staff of harm reduction programmes may also provide information including, but not limited to, the following:

(a) drug dependence treatment services and other health services;
(b) means of protection against transmissible diseases, including blood-borne diseases such as HIV;
(c) the risks associated with the use of controlled substances;
(d) harm reduction information specific to the drug being used, including safe injecting and inhaling practices;
(e) legal aid services;
(f) employment and vocational training services and centres; and
(g) available support services for people with drug dependence and their families.

Distribution and possession of sterile syringes and related material

(1) An authorized person or organization may distribute sterile syringes and related material via one or more of the following means:

(a) prison nurses or physicians based in a medical unit or other area(s) of the prison;
(b) prisoners trained as peer outreach workers;
(c) non-governmental organizations or health professionals who enter the prison for this purpose;
(d) one-for-one automated sterile syringe-dispensing machines.

(2) Wherever possible, sterile syringes and related material shall be made available to prisoners without the necessity of the prisoner identifying himself or herself to prison authorities.

(3) The Ministry of Internal Affairs, in consultation with the Ministry of Health shall establish rules for the safe storage of syringes possessed by prisoners in accordance with this law.

(4) The sterile syringe programme shall include measures to encourage safe disposal of syringes and monitor the number of syringes distributed and the number in storage.

(5) Sterile syringes and related material distributed by harm reduction programmes shall be used only in accordance with this law and any other applicable Regulations or institutional policies established by the relevant authority.

(6) The distribution and possession of syringes and related material in prison in accordance with this law shall not constitute a criminal nor administrative offence, nor shall such items be admissible as evidence of illegal drug use for the purposes of determining any criminal or administrative offence.

Availability of bleach as a disinfectant

(1) Bleach and instructions on using bleach as a disinfectant shall be made available in accordance with this law and any other applicable Regulations or institutional policies established pursuant to this law.

(2) Any such Regulations or policies established pursuant to Section (1) will:

(a) encourage participation of prisoners and their assistance in bleach distribution;
(b) ensure that bleach is available to prisoners in ways that preserve prisoners' anonymity; and
(c) ensure that in no instance shall a prisoner be required to approach a staff member in order to obtain bleach.

(3) Bleach distributed pursuant to this law shall be used only in accordance with this law and any other applicable Regulations or institutional policies established pursuant to this law.

(4) The distribution and possession of bleach in prison in accordance with this law shall not constitute a criminal nor administrative offence, nor shall such items be admissible as evidence of illegal drug use for the purposes of determining any criminal or administrative offence.

Information and education programmes regarding HIV/AIDS, other blood-borne diseases and drug dependence treatment in prisons

(1) The Ministry of Health shall develop and implement information and education programmes in every prison to help prevent the spread of HIV, other blood-borne diseases, and to address drug dependence among prisoners.

(2) In developing such programmes, the Ministry of Health shall use materials that are likely to be effective in reducing transmission of blood-borne diseases within prisons and outside prison following the release of prisoners, as well as providing information on treatment, care and support.

(3) Such programmes required by Section (1) may include peer education and use of non-Ministry of Internal Affairs personnel, including delivery of these programmes by community-based organizations.

(4) Materials shall, as much as possible, be available in the languages of the relevant populations, shall take into account the literacy level of the relevant populations, and shall be sensitive to the social and cultural needs of the relevant populations.

Responsibility of the Ministry of Health for providing training and education

The Ministry of Health is responsible for ensuring:

(a) that training and education are provided to staff and prisoners on a regular basis, and that such training and education include the principles of standard precautions to prevent and control blood borne diseases; the personal responsibility of staff and prisoners to protect themselves and others at all times; and information on post-exposure prophylaxis, if available;

(b) that training and education provided to prisoners also include information about available services and treatments; and peer education and counselling programmes that include the meaningful participation of prisoners as counsellors; and

(c) that prisoners and staff who may be exposed to blood and body fluids receive training in universal precautions.

Recommendation 26: Ensure access to treatment for prisoners with HIV

To ensure the right of access to equivalent health services, authorities responsible for correctional facilities need to implement universal access to antiretroviral therapy and other needed medications and treatment for HIV-positive prisoners. This obviously requires more than mere legislative amendments, but one important step would be to create a clear legal provision that recognizes prisoners' rights in this area. To this end, a provision such as the following should be inserted into the *Law "On HIV"* and/or the *Penal Code*:[1388]

Right to equal and adequate health care for prisoners

(1) HIV testing for prisoners is conducted only on a voluntary basis.

(2) A prisoner who has tested positive for infection with HIV is entitled to adequate health care, counselling and referrals to support services while in prison.

1388 See *Legislating for Health and Human Rights: Model Law on Drug Use and HIV/AIDS*, Module 5: Prisons, pp. 16-17.

(3) Health practitioners shall provide prisoners with protection of their physical and mental health and treatment of disease of the same quality and standard as is afforded to those who are not imprisoned or detained.

While it is recommended that there be explicit reference to HIV, ideally, such an amendment would be worded more broadly to extend to needed health care services and medications beyond just HIV-specific care.

Recommendation 27: Protect the confidentiality of prisoners' health information

The national expert group has recommended amendments to the *Penal Code,* including adding provisions regarding the obligation on prison system personnel to maintain the confidentiality of medical information of prisoners, including their HIV status. A provision such as the following should be inserted into the *Penal Code*:

Confidentiality

(1) All information on the health status and health care of a prisoner is confidential, and all health care procedures shall be designed so as to preserve the confidentiality of prisoners.

(2) Information referred to in Section (1) shall be recorded in files available only to health practitioners and not to non-health care prison staff. No mark, label, stamp or other visible sign shall be placed on prisoner's files, cells or papers that could indicate his or her HIV status, other than necessary notations inside the medical file in accordance with standard professional practice for recording clinically relevant information about a patient.

(3) Information referred to in Section (1) may only be disclosed:
(a) with the prisoner's consent; or
(b) where warranted to ensure the safety of other prisoners or staff;
with the same principles as generally applied in the community applying to the disclosure.

Recommendation 28: Eliminate discrimination against prisoners with HIV or drug dependence

To eliminate discrimination based on health status that is currently embedded in the law, the *Penal Code* should be amended in a number of ways, as follows:

- Repeal Article 113 of the *Penal Code*, which prohibits transferring prisoners who undergoing compulsory drug dependence treatment and prisoners with infectious diseases (including HIV) to lower-security institutions, which often provide better conditions.

- Repeal Articles 82 and 83 (and related provisions) of the *Penal Code*, which deny prisoners with an infectious disease (including HIV) and prisoners who have not completed drug dependence treatment the possibility of temporary absences from the penal institution (e.g., in the event of a family member's death or illness; as a reward for 'good behaviour').

Discrimination

As noted above, current Uzbek law includes very important provisions prohibiting, in general terms, discrimination against people based on HIV-positive status. Yet at the same time, discrimination is a reality and Uzbek law itself contains discriminatory provisions in other areas. Legal protections against discrimination are important elements of successfully addressing the marginalization that contributes, in multiple ways, to people's vulnerability to HIV and to experiencing even more severely the impact of HIV infection. Uzbek law can be strengthened in several ways in this regard in order to comply with human rights principles.

Recommendation 29: Eliminate HIV testing and other forms of discrimination against people living with HIV in employment or educational settings

The *Law "On HIV"* prohibits refusing to employ someone or dismissing someone from employment based on HIV status.[1389] However, despite this prohibition, current Uzbek law itself discriminates unjustifiably. As noted above (Recommendation 19), there is no justification for the current practice of mandatory HIV testing of military recruits or personnel and dismissal of those who test HIV-positive; this should be abolished.

Furthermore, it is not justifiable discrimination to maintain mandatory HIV testing of various other categories of employees (e.g., police officers; employees of the National Security Service and the Ministry of Defence; physicians, surgeons and gynecologists; food industry workers). Such testing is not necessary for HIV prevention purposes. Appropriate universal precautions can and should be taken by health care workers to protect both themselves and patients against the risk of transmission of various blood-borne diseases, and there is no risk posed by food industry workers who are HIV-positive. Nor is it correct or justifiable to assume that mere HIV-positive status means an employee is incapable of performing the essential duties of such jobs. The Government of Uzbekistan should ensure that amendments to the *Law "On HIV"* prohibit agencies and organizations from adopting such discriminatory policies and practices.

In addition, it would be useful to recognize explicitly that requiring HIV testing before or during employment or attendance at an educational institution amounts to unjustified discrimination based on health status.[1390] A legislative amendment to the *Law "On HIV"* should prohibit such practices. A provision could be worded as follows:

> Discriminating against a person on the basis of his or her HIV infection or AIDS diagnosis is prohibited, including but not limited to such contexts as employment or education. It is unlawful discrimination to require that a person be tested for HIV as a condition of employment or enrolment in an educational institution, either before or during employment or enrolment.

Recommendation 30: Eliminate discrimination against drug-dependent persons in employment or educational settings

Requiring drug testing *before* employment or enrolment in an educational institution is also unjustified discrimination based on health status. Requiring testing for drug use *during* employment may only be potentially justifiable in quite limited circumstances, such as limiting testing to positions that are safety-sensitive and then only in cases where there are reasonable grounds to suspect impairment or possibly random drug testing of persons returning to work after receiving drug dependence treatment. There is a need to differentiate between people using drugs from time to time and those who are dependent on them.

The *Law "On narcotic drugs and psychotropic substances"* (or perhaps a new law on treatment of drug dependence, if adopted) should explicitly formalize the general rule that discrimination based on drug use is illegal (although there may be some circumstances in which differential treatment on this basis may be justifiable). The national expert group is of the view that such a provision in the law will help challenge stigma faced by people who use drugs. It is recommended that the law be amended to include a provision along the lines of the following:[1391]

> **Discrimination based on drug use**
> (1) Absent a reasonable justification given the circumstances of the case, it is prohibited to discriminate against a person, or a relative or associate of the person, on the ground that the person uses or has used drugs, or is perceived to use or have used drugs.

1389 *Law "On HIV"*, Article 10.

1390 E.g., see UNAIDS/OHCHR, *International Guidelines on HIV/AIDS and Human Rights*, para. 149. Similar analysis would apply to discrimination against someone based on something like infection with hepatitis B or C virus (HBV, HCV) or on the basis of a sexually transmitted infection. Given modes of transmission, many people who inject drugs are vulnerable to infection with other blood-borne diseases such as HBV or HCV, in addition to HIV, and may face discrimination on that basis, as has been observed in other jurisdictions. In making amendments to strengthen protection against HIV-related discrimination in an area such as employment or educational contexts, it would be advisable to explicitly include protection against discrimination based on such other diseases.

1391 See *Legislating for Health and Human Rights: Model Law on Drug Use and HIV/AIDS*, Module 7: Stigma and discrimination, pp. 13-15.

> (2) It is unlawful discrimination to require that a person undergo drug testing as condition of enrolment in an educational institution, either before or during enrolment.
>
> (3) It is unlawful discrimination to require that a person undergo drug testing as a pre-condition of employment. Making drug testing a condition of continued employment is permitted only in positions, as designated by [suitable government authority], where impairment while at work may pose a significant risk of harm to the individual employee or to others *and* where there are reasonable grounds to suspect that the individual employee may be impaired by drug use.

According to the national expert group, any limits on professional activities or occupations that people who use drugs may hold should be strictly rationalized and necessary. Such decisions should be made by a qualified committee, based on individual circumstances, and should be reviewed regularly (e.g., annually) to determine if they remain necessary.

Recommendation 31: Respect and protect family relationships
The *Law "On protection of public health"* (Article 13) states that citizens are protected against discrimination regardless of what disease they may have. Yet, as noted above, drug dependence can be a basis for denying someone's application to adopt or deprivation of parental rights (custody of a child). This blanket discrimination simply on the basis of a health condition, without regard for individual circumstances and what is in "the best interests of the child", is not justified. In light of this:

- Article 79 of the *Family Code* should be amended to repeal the explicit blanket provision on deprivation of parental rights if a person is drug-dependent.
- Article 152 of the *Family Code* should be amended to repeal the explicit blanket provision that prevents a person with drug dependence from adopting or receiving custody of a child.

APPENDIX 1

Comparative tables of legal classification and threshold quantities of controlled psychoactive substances in project countries

TABLE 1: Legal classification of selected controlled psychoactive substances

	Narcotic drugs and psychotropic substances, turnover of which is prohibited (including for medical purposes)				**Narcotic drugs and psychotropic substances turnover of which is controlled** (allowed for use for medical purposes, but strictly regulated)			
	Narcotic drugs		**Psychotropic substances**		**Narcotic drugs**		**Psychotropic substances**	
Azerbaijan	Cannabis Cocaine Hashish	Heroin Khat Poppy seed	Amphetamine Cathine Cathinone		Methadone	Morphine Thebaine	Buprenorphine Themazipam	
Kazakhstan	Hashish Heroin Cannabis	Cocaine Poppy seed Poppy (dried)	Cathinone		Codeine Morphine Methadone	Thebaine Opium	Amphetamine Buprenorphine	
Kyrgyzstan	Heroin Desomorphine Cannabis and cannabis resin Cannabis oil Poppy straw and poppy straw concentrate		Cathinone MDMA Cat		Cocaine Coca leaf Methadone Morphine	Opium Thebaine Codeine	Amphetamine Metamphetamine Buprenorphine Cathine	
Tajikistan	Cannabis Hashish Heroin		Cathinone		Cocaine Codeine Methadone Morphine Thebaine		Amphetamine Buprenotphine Cathine Themazipam	
Turkmenistan	Amphetamine Cannabis Cocaine Heroin	Opium and derivatives Poppy (dried)	Cathinone LSD MDMA and derivatives		Buprenorphine Trimeperidine Codeine Methadone	Morphine Somnbrevine	Barbital Kethamine Temazipam	
Uzbekistan	Cannabis Cathine Heroin Cathinone Hashish	Khat Methadone Poppy (dried) Poppy seed	n/a		Amphetamine Buprenorphine Cocaine	Codeine Morphine Thebaine		

TABLE 2: Threshold amounts of selected controlled psychoactive substances triggering criminal or administrative liability[1]
(Unless specified, amounts in grams)

	Heroin				**Hashish**				**Methadone**				**Cocaine**			
Azerbaijan	Amount for personal use **<0,15**		Large amount **<2**		Amount for personal use **<1**		Large amount **<100**		Amount for personal use **<0,02**		Large amount **<1,6**		Amount for personal use **<0,02**		Large amount **<1**	
Tajikistan	Small **0,5 – 10**	Minor **10 – 100**	Large **100 –1000**	Extra large **>1000**	Small **20 – 100**	Minor **100 – 500**	Large **500 – 5 kg**	Extra Large **>5 kg**	Small **0,5 – 10**	Minor **10 – 100**	Large **100 – 1000**	Extra large **>1000**	Small **0,5 – 10**	Minor **10 -100**	Large **100 – 1000**	Extra large **>1000**
Kazakhstan	Small **0 – 0,01**	Large **0,01 – 1,0**	Extra large **≥1,0**		Small **0,5 –5,0**	Large **5,0 – 200**	Extra large **≥200**		Small **0 – 0,01**	Large **0,01 – 1,0**	Extra large **≥1,0**		Small **0 –0,01**	Large **0,01 – 1,0**	Extra large **≥1,0**	
Kyrgyzstan	Small **≤1**	Large **1 – 30**	Extra large **>30**		Small **≤3**	Large **3 – 90**	Extra large **>90**		Small **≤0,1**	Large **0,1 – 3**	Extra large **>3**		Small **≤0,03**	Large **0,03 – 0,9**	Extra large **>0,9**	
Turkmenistan	Small **0,025 – 5,0**	Large **5,0 – 50,0**	Extra large **>50,0**		Small **1,0 – 25,0**	Large **25,0 – 250,0**	Extra large **>250,0**		Small **0 – 0,02**	Large **0,02 –1,5**	Extra large **>1,5**		Small **0,02 – 1,0**	Large **1,0 – 20,0**	Extra large **>20,0**	
Uzbekistan	Small **n/a**	Exceeding small **0,001 – 0,005**	Large **>0,005**		Small **0,1**	Exceeding small **0,1 – 1,0**	Large **>1,0**		Small **0,01**	Exceeding small **0,01 – 0,1**	Large **>0,1**		Small **0,01**	Exceeding small **0,01 – 0,1**	Large **>0,1**	

1 In Azerbaijan, possession of drugs for personal use leads to administrative liability; criminal liability starts for possession of drugs exceeding amounts for personal use; in Tajikistan, possession of drugs less than "small" amounts leads to administrative liability; in Kazakhstan, Kyrgyzstan, Turkmenistan and Uzbekistan possession of small amounts leads to administrative liability, possession of amounts exceeding small, leads to criminal liability.

TABLE 2., Threshold amounts of selected controlled psychoactive substances triggering criminal or administrative liability
(Unless specified, amounts in grams)
continued

	Cannabis (Dried)				Buprenorphine			Amphetamine				Morphine			
Azerbaijan	Amount for personal use **5**		Large amount **500**		Amount for personal use**<0,05**		Large amount **<2,5**	Amount for personal use **<0,15**		Large amount **<2**		Amount for personal use **<0,05**		Large amount **<2,5**	
Tajikistan	Small **100 – 200**	Minor **200 – 1000**	Large **1000 – 10 kg.**	Extra large **>10 kg.**	**Not included in the Schedules**			Small **0,5 – 10**	Minor **10 – 100**	Large **100 – 1000**	Extra large **>1000**	Small **0,5 – 10**	Minor **10 – 100**	Large **100 – 1000**	Extra large **>1000**
Kazakhstan	Small **0,5 – 50**	Large **50 – 1000**	Extra large **≥1000**		Small **0 – 0,0012**	Large **0,0012 – 0,12**	Extra large **≥0,12**	Small **0 – 0,02**	Large **0,02 – 3,0**		Extra large **≥3**	Small **0 – 0,01**	Large **0,01 – 1,0**		Extra large **≥1,0**
Kyrgyzstan	Small **≤20**	Large **above 20 – 600**	Extra large **>600**		Small **≤0,8**	Large **above 0,8 – 24**	Extra large **>24**	Small **≤1,5**	Large **above 1,5 – 45**		Extra large **>45**	Small **≤1**	Large **above 1 – 30**		Extra large **>30**
Turkmenistan	Small **5,0 – 50,0**	Large **50,0 – 500,0**	Extra large **>500,0**		Small **0 – 0,0012**	Large **0,0012 – 0,12**	Extra large **>0,12**	Small **0,05 – 0,5**	Large **0,5 – 5,0**		Extra large **>5,0**	Small **0,01 – 1,0**	Large **1,0 – 5,0**		Extra large **>5,0**
Uzbekistan	Small **0,5**	Exceeding small **above 0,5 – 5,0**	Large **>5,0**		Small **0,0012**	Exceeding small **above 0,0012 – 0,012**	Large **>0,012**	Small **0,02**	Exceeding small **0,02 – 0,3**		Large **>0,3**	Small **0,01**	Exceeding small **0,01 – 0,1**		Large **>0,1**

	Cannabis (plant)				Poppy (dried)				Opium (raw)			
Azerbaijan	Amount for personal use n/a		Large amount n/a		Amount for personal use n/a		Large amount n/a		Amount for personal use n/a		Large amount n/a	
Tajikistan	Small 5 – 10 plants	Minor 10 – 50 plants	Large 50 – 500 plants	Extra large 500 plants	Small 20 – 100	Minor 100 – 500	Large 500 – 5 kg	Extra large >5 kg	Small 5 – 100	Minor 100 – 1000	Large 1000 – 10 kg	Extra large >10 kg
Kazakhstan	Small n/a	Large n/a		Extra large n/a	Small 0,5 – 20,0	Large 20,0 – 500		Extra large >500	Small 0,1 – 2,0	Large 2,0 – 100,0		Extra large >100
Kyrgyzstan	Small ≤15 plants	Large above 15 – 30		Extra large >30 plants	Small ≤50	Large above 50 – 1500		Extra large >1500	Small ≤3	Large above 3 – 90		Extra large >90
Turkmenistan	Small 5 – 10 plants	Large 10 – 20 plants		Extra large 20 plants	Small 50,0 – 1000,0	Large 1000,0 – 5000,0		Extra large >5000,0	Small 1,0 – 50,0	Large 50,0 – 500,0		Extra large >500,0
Uzbekistan	Small n/a	Exceeding small n/a		Extra large n/a	Small 1	Exceeding small above 1,0 – 10,0		Large >10	Small 0,1	Exceeding small 0,1 – 1,0		Large >1

The regulation of schedules/lists of narcotic drugs and psychotropic substances in the project countries varies.

In Azerbaijan, there are the three lists of narcotic drugs, psychotropic substances and precursors, the turnover of which is prohibited, limited or controlled: List I of substances turnover of which is prohibited entirely; List II of substances of which only limited turnover is permitted (i.e., substances may only be imported by state agencies); and List III of substances of which turnover of which is permitted and controlled by the state.[1]

In Kazakhstan, there is a Schedule (Список) of narcotic drugs, psychotropic substances and precursors that are controlled.[2] The Schedule consists of four Tables (Таблицы). Table I includes narcotic drugs and psychotropic substances the use of which for medical purposes is prohibited. Table II includes drugs and substances the use of which for medical purposes is strictly controlled. Table III contains drugs and substances that are used for medical purposes and are controlled by the state. Table IV contains precursors that are controlled in Kazakhstan.

The same approach as in Kazakhstan is taken in Uzbekistan[3] and Turkmenistan.[4]

In Kyrgyzstan,[5] narcotic drugs are divided into four Schedules (списки). Schedule I lists narcotic drugs that are dangerous if misused but can be used for medical purposes. Schedule II lists less dangerous narcotic drugs that can be used for medical purposes. Schedule III lists some preparations of narcotic drugs that are exempt from some measures of control. Schedule IV lists narcotic drugs that are prohibited for use in Kyrgyzstan. Similar Schedules exist for psychotropic substances: Schedule I lists psychotropic substances prohibited within Kyrgyzstan. Schedule II lists psychotropic substances that are dangerous if misused but that can be used for medical purposes. Schedule III lists less dangerous psychotropic substances that can be used for medical purposes. Schedule IV lists less dangerous psychotropic substances which are prohibited for use. There are also separate lists of precursors and plants that contain narcotic substances prohibited for growing. The threshold amounts of morphine indicated in Table 1 are those for " other preparations of morphine"; the respective threshold amounts for "medicinal morphine" are as follows: 0.1, above 0.1 to 3.0, and above 3.0

In Tajikistan, there is a national list of narcotic drugs, psychotropic substances and precursors and their amounts that are prohibited for use.[6]

1 Law of the Republic of Azerbaijan «On Lists of amounts of narcotic drugs, psychotropic substances and precursors, turnover of which is prohibited, limited or controlled in Azerbaijan. ["Об утверждении списков наркотических средств, психотропных веществ и прекурсоров, оборот которых на территории Азербайджанской Республики запрещен, ограничен и контролируется"], 28 June 2005, № 961

2 The Schedule is adopted by the Law on narcotic drugs, psychotropic substances, precursors and (Закон Республики Казахстан от 10.07.1998 N 279-1 "О наркотических средствах, психотропных веществах, прекурсорах и мерах противодействия их незаконному обороту и злоупотреблению ими").

3 *Law "On narcotic drugs and psychotropic substances"* [О наркотических средствах и психотропных веществах], Law No. 813-1, (19 August 1999), Article 4; and State Commission of Uzbekistan on Drug Control, "List of narcotic drugs determining small, exceeding small and large quantities when detected in illegal possession or trafficking" [Перечень наркотических средств с отнесением их количества к небольшим, превышающим небольшие и крупным размерам при обнаружении в незаконном владении и обороте], Decision No. 3 (22 May 1998).

4 *Law of Turkmenistan "On narcotics, psychotropic substances, precursors and measures to counter their illegal circulation"* [О наркотических средствах, психотропных веществах, прекурсорах и мерах противодействия их незаконному обороту], 9 October 2004, Article 2.

5 *Law of Kyrgyzstan "On narcotic drugs, psychotropic substances and precursors"*, Law No. 66 (22 May 1998), with amendments of 4 July 2005, No. 90, Article 2; and Government Resolution "On narcotic drugs, psychotropic substances and precursors under control in Kyrgyz Republic", No. 543 (9 November 2007), with appendices.

6 *Law of Tajikistan "On narcotic drugs, psychotropic substances and precursors"*, Law No. 874 (10 December 1999).

APPENDIX 2

TOOL FOR THE ASSESSMENT OF NATIONAL LEGISLATION ON ACCESS TO
HIV PREVENTION AND TREATMENT FOR
PEOPLE WHO USE DRUGS AND PRISONERS

UNODC
CANADIAN HIV/AIDS LEGAL NETWORK

2010

1. DESCRIPTION

This Assessment Tool is designed for the purpose of analyzing national laws and their implementing instruments, and some elements of practice, so as to assess the availability and accessibility of HIV prevention and treatment for vulnerable groups of the population, namely, for people who use drugs and prisoners Since the Assessment Tool focuses on assessing legislative guarantees of HIV prevention, treatment and care, .. the analysis made with its use may assist countries in in reforming their legislation and policy to improve prevention and treatment of HIV-infection in general and especially these two groups of population.The Assessment Tool is based on international human rights standards, particularly the right to enjoy the highest attainable standard of health. This version of the Assessment Tool was prepared specifically for the region of Central Asia and Azerbaijan, the countries participating in this UNODC project, and was developed taking into account specific characteristics of political and legal systems in this region. The Assessment Tool can be adapted and used for assessments of the legislation and policy in other countries and regions.

The Assessment Tool was designed to help assess to what extent the national legislation guarantees respect for, and observance and protection, of human rights, including the availability of services to prevent and treat HIV to injection drug users and prisoners and protection against discrimination of these vulnerable populations. The Assessment Tool also includes such areas as adequate treatment of drug dependence and harm reduction services, as key elements of HIV prevention. The document contains questions and tables for assessing the extent to which national legislation corresponds to international legal standards and best practices in the field of HIV prevention and treatment. Completion of the Assessment Tool should help experts identify spheres where the national legislation and legal practice create barriers or lead to ineffective HIV prevention and treatment for vulnerable groups such as people who use drugs and prisoners, or can potentially violate human rights.

The Assessment Tool also includes guidelines to conduct an analysis for national experts. To assist national experts to use the Assessment Tool and carry out assessment of their national legislation, training modules were prepared on international human rights standards, the right to health, rationale for reforming laws and policies on drugs and prisons, and best international practices in the area of HIV prevention, treatment, and harm reduction services for people who use drugs and for prisoners.

Structure of the Assessment Tool

The Assessment Tool is divided into the following sections:

1. **International law**: international treaties applicable to the country.
2. **National legal system**: the basics of judicial and legal systems, legislative drafting and amendments.
3. **National programmes/plans/strategies on drugs and HIV:** the presence of provisions and activities aimed at treatment of drug dependence, and the prevention of HIV among people who use drugs and prisoners.
4. **Administrative and criminal law issues**: analysis of administrative and criminal law provisions related to drug use and possession of small amounts of narcotic drugs for personal use, referal for drug testing by law enforcement, the availability of diversion programmes for non-violent drug-related offences.
5. **Health care services**: availability and accessibility of public health services; drug dependence treatment; HIV testing and treatment; patients' rights, including the confidentiality of health information; and the availability of harm reduction services.
6. **Prisons:** HIV prevention and treatment measures in the penitentiary system, including measures to address drug use in prisons (e.g., drug dependence treatment, needle and syringe programmes)
7. **Anti-discrimination provisions:** limitations of rights of people who use drugs and people living with HIV in national legislation; participation in decision-making.

2. METHODOLOGY

The Assessment Tool is based on international human rights standards and was developed taking into account international declarations and recommendations on drugs, prisons, HIV and AIDS by international organizations, in particular the United Nations (UNAIDS, World Health Organization, United Nations Office on Drugs and Crime, and the United Nations Office of the High Commissioner for Human Rights).

A key reference document used in developing the Assessment Tool is *Legislating for Health and Human Rights: Model Law on Drug Use and HIV/AIDS* (Toronto: Canadian HIV/AIDS Legal Network, 2006), online in both English (www.aidslaw.ca/modellaw) and Russian (www.aidslaw.ca/modellaw-ru). The model law gives examples of best legislative practices of HIV prevention and treatment for people who use drugs and prisoners. The model law resource should be used by national experts as a basis for drawing up the recommendations on reforming the legislation. Also, the following legal documents were used in preparation of the Assessment Tool:

- *Universal Declaration of Human Rights* (1948);
- *International Covenant on Civil and Political Rights* (1966);
- *International Covenant on Economic, Social and Cultural Rights* (1966);
- UN Committee on Economic, Social and Cultural Rights, *General Comment No. 14: The Right to the Highest Attainable Standard of Health* (2000);
- OHCHR & UNAIDS, *International Guidelines on HIV/AIDS and Human Rights*, Consolidated version (2006);
- IPU, UNAIDS & UNDP, *Taking action against HIV: Handbook for Parliamentarians* (2007);
- *WHO Guidelines on HIV infection and AIDS in Prisons* (1993);
- UN General Assembly, *Basic Principles for the Treatment of Prisoners* (1990);
- UN General Assembly, *Standard Minimum Rules for the Treatment of Prisoners* (1955);
- UN General Assembly, *Declaration of Commitment on HIV/AIDS* (2001);
- WHO/UNDCP/UNAIDS, *Position Paper: Substitutive maintenance therapy in the management of opioid dependence and HIV/AIDS prevention* (2004);
- UNDCP Legal Affairs Section, *Flexibility of treaty provisions as regards harm reduction approaches*, Decision 74/10 (2002);
- *Dublin Declaration on Partnership to fight HIV/AIDS in Europe and Central Asia* (2004); and many others.

3. INSTRUCTIONS ON USING THE ASSESSMENT TOOL

Within the scope of the present project, the national experts should :

- Inform themselves about international standards listed above and with the *Model Law on Drug use and HIV/AIDS*;
- Complete the Assessment Tool, answering all questions, using international, regional and bilateral treaties, national laws, implementing legislation, regulations and instructions;
- Conduct interviews with stakeholders, including NGO staff, people who use drugs, people living with HIV and current or former prisoners.
- Discuss outcomes of the legislative analysis with corresponding national government bodies, representatives of civil society, people living with HIV and people who use drugs and other stakeholders;
- Draft recommendations on how to improve national legislation governing response to HIV, and how to remove legislative barriers to effective HIV prevention and treatment for people who use drugs and prisoners in the country;
- Carry out meetings, roundtables, discussions and trainings for national decision-makers and stakeholders on international standards and proposed recommendations.

While completing the Assessment Tool, national experts will compare the existing national legislation to the international standards in the field of human rights and to the *Model Law on Drug use and HIV/AIDS* and develop recommendations on reforming the national legislation in the field of prevention of HIV among people who use drugs and prisoners. During the analysis of national legislation and regulations, experts should take into account: laws and implementing legislation that might directly or indirectly contribute to discrimination, stigmatization or limitation of the rights of people who use drugs, sex workers,

prisoners and other groups at risk of HIV; provisions or policies that increase vulnerability to HIV, including strict administrative and criminal legislation and polices in relation to people who use drugs.

Documents to include in the analysis

- National programmes/strategies on HIV, drug control and reform of the penitentiary system;
- Constitutions, codes and laws;
- Presidential decrees, ministerial and departmental resolutions and instructions;
- Guidelines on interpretation of the laws, published for the public by an establishment or enforcement authority;
- Court decisions;
- Other documents relevant to the subject.

It is important to gather and take into account all relevant documents. Provisions of the Constitution or criminal and administrative codes might be subject to broad interpretation by implementing acts such as instructions or government resolutions, which might unintentionally negatively affect people who use drugs and prisoners. When conducting an assessment it is necessary to identify such legal documents, although they can be difficult to find.

Some sections of the Assessment Tool ask experts to collect information about statistics, facts and practices. In some respects, conclusions of the assessment should be based not only on legal provisions, but also on the reality of how these provisions are (or are not) implemented. In cases where national experts have doubts about the enforceability and practical effects of the legislation, they should provide comments. For example, if harm reduction programmes are not explicitly prohibited by laws, but are not implemented effectively because outreach workers or people who use drugs are afraid of prosecution, this situation should be described in the report.

Members of the expert group might identify other pertinent areas. In this case, expert group members should include these areas in their analysis and explain their relevance. At the end of each section, there should be a summary of the collected information and key conclusions and recommendations. Exact citations of provisions of laws and regulations should be noted. If possible, a copy of the laws and regulations should be made and kept available for review.

Conducting interviews

To ensure comprehensive analysis, national experts are asked to conduct interviews with a suitable number of people who have experience in the area in question (service providers, people who use drugs and prisoners). This is required in order to have a clear picture about the situation in the country in a certain area; to identify situations in which laws are not observed or are interpreted broadly and thus hinder access to HIV prevention and treatment for people who use drugs and prisoners. During the interviews, national experts are requested to get a picture on the real availability of HIV prevention programmes and medical services to people who use drugs and prisoners. To this end, national experts should interview <u>at least</u> one representative from each of the following groups:

1) people who use drugs;
2) people living with HIV;
3) sex workers;
4) prisoners or former prisoners and organizations working in prisons;
5) harm reduction service providers, outreach workers;
6) prison staff;
7) health care personnel, drug dependence treatment specialists, AIDS centre staff;
8) law enforcement personnel;
9) judges, public prosecutors working with offences related to drugs.

Preparing the country report

National expert reviewers should include the following information in the country report:

- completed Assessment Tool, identifying gaps in legislation or its enforcement;
- priorities identified in reforming the legislation to improve HIV prevention and treatment for people who use drugs and prisoners;
- draft recommendations;
- if feasible, draft actual legislative amendments (which could be based on the *Model Law on Drug Use and HIV/AIDS*); and

a plan developed for introdction of the recommendations in the country.

Findings of the country report will be used for a comprehensive integrated report, summarizing conclusions and recommendations from all project countries, which will later be used to advocate proposed reforms.

Self-assessment check-list

National experts are also asked to fill in the self-assessment check-list, designed to assess the conformity of national legislation with the *Model Law on Drug use and HIV/AIDS* and international standards in the field of human rights and harm reduction. The check-list will be useful for monitoring the development and the review of the national legislation in the area of HIV prevention and treatment for people who use drugs and prisoners.

Training for national experts on international standards of HIV prevention and treatment and the application of the Assessment Tool

In the course of the training, detailed information on human rights-based approaches to HIV prevention and treatment, international human rights standards and especially the right to health are presented to national expert teams. Provisions of the *Model Law on Drug use and HIV/AIDS*, and UN recommendations on HIV, drug use and drug dependence treatment, and HIV prevention and treatment in prisons should be covered by trainers. Effective, evidence-based harm reduction interventions are also covered (e.g., needle and syringe programmes, opioid substitution therapy, voluntary treatment of drug dependence), as described in the Training Module (see Appendix 3).

It is expected that during the training, participants will:

- deepen their knowledge of international human rights standards in the area of HIV prevention and treatment for people who use drugs and prisoners;
- acquire knowledge on the *Model Law on Drug Use and HIV/AIDS* as a key reference for the future legislative reforms;
- acquire knowledge and skills on using the Assessment Tool for reviewing national legislation and collecting strategic documents relevant to the availability of HIV prevention and treatment services to people who use drugs and people in prison;
- draft a plan for reviewing and revising national legislation and preparing recommendations for amendments;
- agree on sharing the workload among the members of the working group, based on their respective areas of expertise, and identify priorities; and
- discuss possible difficulties in working with the legislation, the subsequent reforms of the legislation and legal practices, and ways to overcome them.

4. QUESTIONS FOR ASSESSMENT OF LEGISLATION

I. **International Law**

1. What international and regional conventions and treaties has the country ratified in the area of human rights?

Table 1. International and regional conventions and treaties related to human rights the country ratified

International document	Date of ratification (or not ratified)	Reservations	Comments
International Covenant on Civil and Political Rights (1966)			
Optional Protocol to the International Covenant on Civil and Political Rights (1966)			
International Covenant on Economic, Social and Cultural Rights (1966)			
Optional Protocol to the International Covenant on Economic, Social and Cultural Rights (2008)			
Convention on the Rights of the Child (1989)			
Convention Against Torture (1984)			
Convention on Elimination of All Forms of Discrimination against Women (1981)			
International Convention on the Elimination of All Forms of Racial Discrimination (1969)			
European Convention on Human Rights (1953) (and its Protocols)			
Other (please list)			

2. Which international and/or regional human rights organizations has the country joined?
3. What is the status of international treaties on human rights with respect to national laws? (Do the provisions of national law stipulate the supremacy of international law?)
4. What conventions or other documents related to controlling narcotics has the country ratified or endorsed?

Table 2. Conventions or other documents related to drug control ratified by the country?

International document	Date of ratification (or not ratified)	Comments
Single Convention on Narcotic Drugs 1961		
Protocol Amending the Single Convention on Narcotic Drugs, 1972		
Convention on Psychotropic Substances, 1971		
United Nations Convention Against Illicit Traffic in Narcotic Drugs and Psychotropic Substances, 1988		
UN General Assembly's Declaration on the Guiding Principles of Drug Demand Reduction, 1998		
Other (please list)		

5. What bilateral or regional agreements on drugs control has the government signed?

II. National legal system and relevant agencies for HIV and controlled drugs

6. Describe the hierarchy of national legislation (constitution, codes, laws, regulations).
7. Is there a Constitutional Court in the country? What persons and entities have right to bring a case before the Constitutional Court of the country?
8. What persons and associations possess the right of initiating a new legislation?
9. Are legislative acts and bylaws subject to publication in official media?
10. Describe the judicial system of the country. Which courts have jurisdiction over the cases involving drugs? Are there specialized courts that deal with drug– related cases?
11. What impact (if any) do judicial precedents have on the development of legislation and legal practices?
12. What categories of people are eligible for free legal assistance (appointed lawyer)? Do people charged with drug-related crimes have access to free (and adequate) legal assistance? Is there any agency that provides free legal assistance to the population?
13. Describe the national system of human rights protection, including agencies and their powers.
14. Describe the jurisdiction and powers of law enforcement bodies related to prevention and investigation of drug-related crimes and offences.
15. Describe the system of drug control, its objectives and functions. What agency is responsible for the development and implementation of drug control legislation and policy?
16. Describe national HIV agencies, including 1) their functions and powers and; 2) the participation of people who use drugs and people with HIV in their activity.

III.A. National programmes, strategies and action plans on drugs

17. What national programmes, strategies or action plans on drugs exist in the country? Describe the main elements of the programme, including: (1) drug use prevention; (2) drug dependence treatment; (3) harm reduction services; (4) law enforcement measures;.
18. Does the programme mention preventive measures (including harm reduction services) and drug-dependence treatment in penal institutions?
19. Does the programme have a prescribed budget? What are the sources of financing of the programme? What portion of the budget is spent on drug-dependence treatment and harm reduction services?
20. What bodies are responsible for development of the programme, its implementation and assessment of its effectiveness?
21. How does civil society participate in the process of development and implementation of the programme (e.g. organizations working in the field of harm reduction, people who use drugs)? Does the programme include any mechanisms for civil society control over implementation of the programme?
22. What could be done in order to increase the effectiveness of the programme? Interviews with representatives of civil society may be particularly useful in answering this question.

Describe the elements of the programme using the following table.

Table 3. Drug control programme

Elements of the programme	Included / not included in the programme	Institution or governmental body responsible for implementation of the programme	Comments/brief description
Elements/sections of the programme (law enforcement measures, drug use prevention , drug-dependence treatment, harm reduction services)			
Provisions related to interventions for drug use prevention			
Provisions related to treatment for drug dependence (including opioid substitution treatment)			
Provisions related to harm reduction services (including sterile syringe programmes, pharmacy-based distribution of syringes, safe injection facilities, condom distribution programmes, outreach services)			
Provisions related to involvement of people who use drugs in response to drugs			
Provisions related to addressing drug use in prisons (prevention of drug use, treatment for drug dependence, harm reduction services)			
Provisions related to specific preventive measures aimed for other groups (sex workers, minors, women)			
Other			

IIIB. National programmes, strategies and action plans on HIV

23. What national programmes, strategies or action plans on HIV prevention exist in the country? Describe the main elements of the programme including groups of population to which the programme is directed.
24. What actions are directed to the prevention and treatment of HIV infection among specific groups? (Describe the action and the group to which it is directed)
25. Does the programme mention harm reduction services?
26. Is approval of the national drug control agency needed to expand preventive measures on HIV (e.g. for expanding of sterile syringe programmes or opioid substitution treatment)?
27. How is this programme financed? Is financing adequate? What percentage of the programme's budget goes to HIV prevention?
28. What bodies are responsible for development of the programme, its implementation and assessment of its effectiveness?
29. How does civil society participate in the process of development and implementation of the programme (e.g., organizations working in the field of harm reduction, people who use drugs, people living with HIV)? Does the programme include any mechanisms for civil society control over implementation of the programme?
30. Does the programme contain any provisions on human rights of people living with HIV? Or does it contain any provisions for preventing discrimination of people with HIV and guarantee privacy of people living with HIV?
31. Does the programme contain provisions on HIV prevention and treatment in prisons?
32. What could be done to increase effectiveness of the programme? (Interviews with civil society representatives may be particularly useful in answering this question.)
33. Are there other national programmes, strategies or action plans addressing prevention of sexually transmitted infections (STIs), viral hepatitis or tuberculosis? Do they include provisions related to specific groups of people (e.g. people who inject drugs)? Do they include provisions on prevention and treatment of the above diseases in prisons?

Please describe the elements of the programme using the following table.

Table 4. Programme on HIV prevention

Elements of the programme	**Included / not included in the programme**	**Institution or governmental body responsible for implementation of the programme**	**Comments/ brief description**
The main elements/sections of the programme (prevention and treatment of HIV)			
Provisions on harm reduction services			
Provisions related to actions on HIV prevention for general population			
Provisions related actions on HIV prevention for injecting drug users (including sterile needle and syringe programmes, pharmacy-based distribution of syringes, safe injection facilities, condom distribution programmes, outreach services and opioid substitution treatment)			
Provisions related to actions on HIV prevention in prisons (including educational activities, sterile needle and syringe programmes, condom distribution programmes, outreach services and opioid substitution treatment)			
Provisions on specific actions aimed at other groups of population (pregnant women, sex workers, men who have sex with men)			
Provisions on actions aimed at HIV treatment (including antiretroviral therapy, free medical service for people with HIV and etc.)			
Provisions on reduction of stigma and discrimination			
Other			

IV. Criminal and administrative law issues

Please indicate all legislative provisions, references and quotations from legislation; if possible, include excerpts.

34. Does drug use *per se* lead to criminal or administrative liability?
35. Does the legislation on drugs include a notion of "amount for personal use" or "average consumption dose"?
36. Does the Criminal Code make a distinction between drug possession for personal use and possession for sale?
37. How is drug possession with no intent of sale regulated in the country? If possible,please give details on different drug substances.
38. Please describe the national lists (schedules) of drug substances. Which governmental body or institution is responsible for developing and approving these lists?
39. What is the age of criminal and administrative responsibility for drug-related crime?
40. What drug-related offences lead to administrative liability?
41. Are there any provisions in national legislation stipulating alternatives to criminal liability for non-violent crimes involving drugs?
42. Does legislation provide for non-custodial sentences for offences involving drugs (e.g. conditional sentence, probation, public works)? Would the punishment change in the case of a repeat offence?
43. Does the Criminal Code consider being under the influence of drugs as an aggravating factor?
44. Can drug dependence treatment constitute an alternative to normal criminal sentencing?
45. Can compulsory treatment of drug dependence be used as an alternative to incarceration?
46. Are there provisions in the legislation that exempt the staff or volunteers of harm reduction programmes from possible criminal or administrative liability?
47. Can possession of a syringe or other related materials for drug use lead to liability under national legislation?
48. Can possession of drug-use materials and equipment be considered as facilitation (or incitement) of drug use? What legislation defines and regulates possession of these materials?
49. Can trace amounts of a drug in a syringe or on other related material for drug use be considered a legally sufficient reason for administrative/criminal liability?
50. Is there a prohibition on patrolling by police of the sites providing harm reduction programmes and pharmacies?
51. What are the legal grounds for police to refer a person for drug testing? (suspicion of drug use, suspicion of committing an offence)
52. Can confiscation of property be imposed in drug-related cases?
53. Is pre-trial detention usually imposed in drug-related offences?

Please create a table of liability for drug-related offences and indicate the maximum and the minimum penalties for these crimes. In cases where the penalty depends on the type of drug used, please indicate these drugs (e.g., heroin, cocaine and other commonly used drugs).

54. Does refusal to undertake drug/HIV/STI testing or HIV/drug dependence/STI treatment constitute a criminal or administrative offence?
55. Does sex work/prostitution constitute a criminal or administrative offence?
56. Does sexual intercourse between two consenting adults of the same sex constitute a criminal or administrative offence?
57. Does transmission of STI and HIV constitute a criminal or administrative offence?
58. Please describe other drug-related offences that might lead to administrative liability (e.g. appearance in public under drug intoxication, etc.)

V. Health care services for people who use drugs

Background information and statistics

Please indicate the number of registered drug users and people dependent on drugs in the country, and people receiving drug dependence treatment, including OST. Please indicate the number of people liv-

ing with HIV who receive antiretroviral therapy in the country. How many of those receiving antiretroviral therapy are people who are known to use drugs? How many are known to be getting hepatitis treatment? Please indicate the number of women getting drug dependence treatment (including OST) and antiretroviral treatment. Are there AIDS centres and drug treatment centres in rural areas? Please describe their accessibility and whether or not there are waiting lists of patients.

59. How is the right to health secured in the national legislation?
60. Is free health service guaranteed for everybody?
61. What documents are needed for access to free health services (e.g., residential registration, insurance card, etc.)?
62. How is access to health care provided to people without residential registration?
63. How accessible is adequate health care services to the unemployed and people without identification documents?
64. Do foreigners, refugees and immigrants have access to health care services? What health services are provided to this category of people on free basis?
65. Are such services as antiretroviral therapy, hepatitis treatment and drug dependence treatment provided free of charge in the country?
66. Are there any recommendations or acts of executive bodies that might hinder access to antiretroviral therapy by people who use drugs?
67. Can drug use constitute a ground for denial of treatment for HIV, hepatitis, or tuberculosis or constitute a ground for exclusion from such treatment programmes?
68. Is there partnership between institutions providing treatment for HIV, drug dependence, tuberculosis and/or hepatitis C? How is referral from one institution to another being regulated or provided? Is it possible to provide simultaneous treatment for the mentioned diseases?
69. Please describe the responsibility of medical personnel for refusal to provide treatment. If there were any cases of prosecution in the past, please indicate their outcome.
70. How are patients' rights, including the confidentiality of medical records, are regulated under the national legislation? Is there a system of holding medical personal accountable for disclosure of medical records?

Drug testing
71. In which circumstances and what bodies can refer an individual to take a drug use test? What documents regulate such referrals?
72. In which circumstances can drug testing take place without the consent of the individual? What are the consequences of refusing to take a drug test?
73. Is there drug testing in schools, universities or other educational institutions? What are the consequences of refusal to undergo drug testing in educational institutions?
74. Is there drug testing in the workplace in the country? What are the consequences of refusal to undergo drug testing requested by employers?
75. Please describe, where applicable, whether or not people who use drugs are limited in the following rights: (a) to get a driving license; (b) to adopt children; (c) to be appointed to certain positions; (d) to vote; (e) to go to certain districts of the city; etc. Please make a list indicating duration of such limitation.

Drug dependence treatment
76. Has there been research conducted in the country on the effectiveness of existing drug dependence treatment methods?
77. How is "drug dependence" understood in the country according to national legislation (as a crime, as a disease, as a disability)?
78. Is there a unified regulatory act on drug dependence treatment? If not, which legislation or regulations have provisions on drug dependence treatment?
79. Are there national standards of drug dependence treatment? If yes, please describe these standards (whether or not they include opioid substitution therapy, post-treatment medical care, rehabilitation).
80. How is payment for drug dependence treatment regulated? For which services related to the drug dependence treatment are there extra charges (officially and in practice)?
81. Is there registration of drug users (and\or drug-dependent individuals) in the country? If yes, for what duration such registration is valid? What are the terms of de-registration? What limitations in rights can such registration entail?
82. What body/institution maintains the registration database?
83. How is confidentiality of information held in such a registry protected? What bodies or officials have access to registration database? Under what circumstances is the exchange of information between health care institutions and the law enforcement permitted by law (if at all)?
84. Are medical workers responsible for reporting to law enforcement bodies cases of drug overdose and/or cases of clients seeking treatment for drug dependence?
85. What organizations (public or private) are allowed to provide drug dependence treatment (including OST)?
86. Is a license or other document needed in order to provide any of the following services: detoxification, in-patient treatment, out-patient treatment, substitution therapy by buprenorphine, methadone or other types of substitution therapy, psychological methods, 12-steps method, etc.?
87. Which elements of drug dependence treatment can be done by in-patient or out-patient drug dependence clinics?
88. Are there provisions in national legislation providing compulsory drug testing while on drug dependence treatment? Can testing positive for drug use lead to exclusion from drug dependence treatment programmes?
89. Is long-term opioid substitution therapy (i.e., maintenance treatment) available in the country? If yes, please describe eligibility for the programme, duration of the treatment, bodies or institutions running the programme, terms of exclusion from the programme, and completion of the programme.
90. If there is no OST, please assess a possibility of introduction of OST in the country.
91. Do persons following OST programmes have the right to be part of the determination of the dose they receive? Does the prescribing physician have discretion to initiate take-away doses to patients?

Compulsory drug dependence treatment
92. Does compulsory drug dependence treatment exist outside of prisons/ in prisons? What are the legal grounds for imposing compulsory treatment and which body has an authority to impose it?
93. What are the legal consequences for failure to comply with the rules of treatment or refusing the treatment?
94. Please indicate duration and terms of termination of compulsory treatment?
95. Have there been any studies of the effectiveness of compulsory drug dependence treatment in the country? What are the criteria of treatment effectiveness?

Overdose management
96. What laws/regulations/acts/instructions regulate the use of naloxone for overdose treatment? Can naloxone be legally provided to drug users as a part of harm reduction programmes (for overdose prevention) by the staff of outreach services?
97. Are there government-based or private programmes (shelters) that provide assistance to homeless drug users?

Table 5. Types of drug dependence treatment

Type of treatment	Availability (yes/no) and number of people on treatment	Type of medical facility (governmental or private facilities)	Form of treatment (out-patient or in-patient)	Availability in prisons
Detoxification				
Use of opioid substances (opioid agonists) for detoxification				
OST using methadone				
OST using buprenorphine				
Take-away doses while on OST				
Rehabilitation				
Counselling and psychosocial support				
The "12 steps" method of recovery from drug dependence and similar programmes (e.g. Narcotics Anonymous)				
Other methods of treatment used for preventing relapse to drug use				
Other methods of treatment directed at reduction of drug use or supervised consumption of drugs				
Other				

HIV testing, treatment and support

98. Is there a specific law on HIV in the country? (If yes, please enclose).
99. Does HIV legislation contain references to HIV prevention among injecting drug users? Are there any other provisions within national legislation that can be used as a legal basis for expansion of HIV prevention measures among risk groups?
100. Does HIV legislation include provisions on HIV prevention measures in prisons?
101. Is there free antiretroviral therapy for everybody in the country? Do people who use drugs and prisoners have access to antiretroviral therapy free of charge? If yes, please indicate the number of people who use drugs and the number of people in prison receiving antiretroviral treatment.
102. Is there a category of "socially significant diseases" or/and "socially dangerous diseases" within national legislation? If yes, which documents describe these definitions? Do these categories include such conditions as HIV infection, viral hepatitis, drug dependence, tuberculosis? What rights and limitations can be imposed by law upon persons with "socially significant/dangerous diseases"?
103. Is there education on HIV and drug use in schools? If yes, please describe which regulations confirm such provisions.
104. Are people living with HIV or those who use or have used drugs involved in HIV prevention work? Is there any legislation regulating such involvement?
105. Does national legislation contain provisions on involuntary HIV testing for the following categories of people: (a) military personnel; (b) public transport workers; (c) tourism and travel workers; (d) sex-workers; (e) others? Are there any provisions in national legislation on mandatory HIV testing when applying for a job, academic studies or social benefits?
106. Are there provisions in national legislation on informed consent to HIV testing? How is "informed consent" defined in national legislation? How is "informed consent" documented?
107. Is there pre- and post test counselling to accompany HIV testing? Who provides pre- and post-test counselling to the patients? Can NGOs provide HIV testing and counselling?
108. Is free and anonymous HIV testing available in the country?
109. Can HIV-positive status or drug dependence serve as a ground for forced abortion or sterilization?
110. Are there provisions on involuntary (compulsory and mandatory) HIV testing? Which categories of people are subject to involuntary HIV testing? Pursuant to which acts/instructions are such tests conducted? Please also describe which body or bodies can authorize compulsory HIV testing and the consequences of refusal to be tested. Please fill in the table below.
111. Which health care services related to HIV are free of charge and which are paid?
112. How is confidentiality of medical records protected? Who has access to medical records databases?

Table 6. Categories of people subject to involuntary HIV testing

Categories of people	Subject to involuntary testing or not	Comments
People who use drugs		
Patients receiving drug dependence treatment		
Patients receiving tuberculosis treatment		
Patients receiving (viral) hepatitis treatment		
Patients with sexually transmitted infections		
Prisoners		
Sex workers		
Men who have sex with men		
Foreign citizens		
Immigrants		
Refugees		
Pregnant women		
Newborns		
Orphans		
State workers		
Medical workers		
Law enforcement officers		
Military personnel		
Draftees (i.e., military conscripts)		
Students (which professions?)		
Other categories of people (specify)		

Patients' rights

113. Does the Constitution of the country, or do other statutory and regulatory documents, mention patients' rights? Are there provisions on the rights of patients in laws related to health care and rights of

consumers in the country? What rights are listed there?
114. Has the right to complain to higher authorities or to the court about the actions of administration of medical institutions been legally stipulated?
115. Are the following rights protected under national legislation of the country: (a) the right to the protection of private life; and (b) confidentiality of medical and private information, including information related to HIV? Are there any provisions on efficient protection of the confidentiality of patients' HIV status?
116. How are databases of AIDS centres maintained? How is confidentiality of information provided? What bodies or organizations have access to these databases?
117. What is the liability for failure to preserve a patient's confidentiality? Have any cases of such liability occurred in the past?
118. In what circumstances can a person's HIV status be disclosed without his/her consent (e.g. to public health agencies, to persons at risk of infection, to family members or sexual partners, to the law enforcement bodies and agencies, etc.)?
119. Is the right to voluntary withdrawal from treatment at any time provided in national legislation? Which categories of people are subject to compulsory treatment of HIV infection? What are the consequences of refusal of treatment?
120. Are there any obligations of citizens or non-citizens related to health (e.g. mandatory checkups)?

Sterile syringe programmes

121. Does legislation contain provisions on sterile needle and syringe programmes? If yes, what body is responsible for the development and implementation of such programmes?
122. Does the government provide sufficient funds for sterile needle and syringe programmes?
123. Does the law restrict pharmacy-based sales of syringes and needles (e.g. prohibition of distribution during the night time, prohibition of distribution to minors, or limited distribution for one person, etc.)?
124. Please describe provisions on the collection and disposal of used syringes.
125. How are records of clients maintained in sterile needle and syringe programmes? How is the confidentiality of information respected in such programmes?
126. What laws and regulations might hamper the work of sterile needle and syringe programmes?
127. Can people who use drugs be involved in the work of sterile needle and syringe programmes (e.g., as peer counsellors and outreach workers)?
128. Please describe the functions of outreach workers (e.g. distribution of information about HIV and AIDS and drug dependence treatment, referral to medical facilities, social and legal aid, assistance in housing and responding to overdoses).
129. How does national legislation regulate outreach services? Are staff members and volunteers of outreach services exempted from potential criminal or administrative liability for outreach work?
130. Other harm reduction services: Are there provisions in national legislation enabling existence of facilities for supervised drug consumption? If not, can national legislation be interpreted to allow such existence?

Groups with specific needs

Women
131. What legal provisions or factors might hamper access of women to drug dependence treatment in the country (e.g., lack or absence of medical facilities for women, fear of losing parental rights if admitting to drug use)? Please conduct interviews with persons working in this field
132. Please compare the documented or estimated number of women who use drugs to the number of men who use drugs.
133. How manyprogrammes/wards are there for women in drug dependence treatment centres? Can women be together with their children while in treatment?
134. Do harm reduction programmes distribute information specifically designed for women? Do they also have specific services for women?
135. What are the legal grounds for limiting parental rights? Can drug dependence or HIV-positive status affect parental rights or guardianship?
136. Can drug use or HIV infection be a barrier to adoption of children?

137. Where do orphans tested HIV-positive or children of people with HIV live? Do orphans with HIV live in general orphanages or in specialized orphanages?

Sex workers
138. How does national legislation define prostitution/ sex work and related activities that may be addressed in criminal or administrative codes (e.g., procuring, organization of premises, communicating for the purpose of prostitution)?
139. What HIV prevention measures are aimed at sex workers? Do NGOs or the government implement HIV prevention measures for sex workers (e.g., distribution of condoms, syringes, information on HIV prevention)?
140. Are there any provisions authorizing compulsory STI or HIV tests or treatment for sex workers?

Youth and students
141. Is there any restriction on the sale or possession of condoms? Can minors purchase condoms?
142. Can minors use sterile needle and syringe programmes? Can minors purchase a syringe in pharmacies?
143. Can minors be subject to compulsory treatment for drug dependence, STIs or HIV infection?
144. Is there compulsory testing on drug use and HIV in educational institutions? Will a minor's parents be informed in the case of positive test results? What are the consequences of refusing HIV testing?

Migrants
145. Do immigrants and refugees have access to health care and HIV prevention programmes?
146. Is there compulsory HIV testing for foreigners? What is the procedure of HIV testing for this category of people? Describe the consequences of HIV-positive status for foreign citizens and the consequences of refusing to take an HIV test.

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VI. Prisons

Background information and statistics
Please indicate the following information (including the source and year of statistical information):
(a) Prison system: number of prisons in the country, their security level and occupancy rate.
(b) Prison population statistics. Indicate as well the percentage of people held for drug offenses (for non-violent and minor crimes) and the security level of prisons in which they are held.
(c) Statistics on the prevalence of HIV infection, viral hepatitis and tuberculosis in prisons. Statistics on drug use (including injecting drug use) in prisons.

147. Please describe the system of subordination of correction departments and agencies.
148. Please describe subordination of health facilities in prisons. Which agency/department is responsible for providing health care in prisons or pre-trial detention centres?
149. Are there working groups/committees on HIV in prisons?
150. Please describe programmes and strategies on HIV-related health disorders in prisons. Are there provisions on HIV prevention, including prevention of transmission via injection?
151. Are there mechanisms for involving NGOs in HIV prevention work in prisons?
152. Please indicate the number of people under house arrest (if applicable), people conditionally discharged from a penalty and people serving non-custodial sentences for drug related offences.
153. Can a person who committed a crime be discharged from criminal liability due to illness?
154. Can a national court mitigate a person's sentence or discharge him or her from a sentence for drug-related crimes based on the person's illness? If yes, how often is such mitigation of penalty applied by courts?
155. Can medical parole be used as an excuse to discharge someone from a prison sentence before the sentence is completed? Are prisoners with HIV entitled for medical parole? Please indicate relevant national legislation.
156. Can prisoners sentenced for drug-related crimes be eligible for conditional early release, transfers to prisons with lower security level or substitution of the remaining term with a more lenient one (due to

acts of amnesty, or for good behaviour and etc.)?
157. What crimes related to drugs require pre-trial detention?
158. Please describe the national legislation regulating pre-trial detention. How often is pre-trial detention applied in drug-related cases?
159. What is the maximum duration of pre-trial detention?

Health care in prisons

160. Do medical facilities in prisons have adequate supplies of medical equipment and medication? (Please make sure to interview current or former prisoners.)
161. Is health care in prisons equivalent to health care for the general population?
162. Have there been any cases of refusal to provide treatment in prisons? Can such refusal be reviewed by a court or tribunal?
163. Is specialized clinical treatment (e.g. for HIV infection) available in prisons?
164. In cases where necessary medical care is not available in prisons, is it possible for prisoners to receive such care outside of prison?
165. Is there a document regulating HIV prevention services and programmes in prisons?
166. How is the confidentiality of medical records protected in prisons? Are there special rules guaranteeing that prisoners' files are not marked in a way that discloses their HIV status?
167. Are there rules aimed at protecting prisoners with HIV from segregation/isolation or any other measures that might disclose their status?
168. Please describe conditions of people tested HIV-positive who are held in prisons. Do prisoners with HIV have any special conditions while serving their penalty?
169. Are prisoners with HIV or tuberculosis held separately from other prisoners? What categories of prisoners are held separately from other prisoners?
170. Is antiretroviral therapy available for people with HIV in prisons?
171. Is treatment for tuberculosis and viral hepatitis B and C available in prisons?
172. Is voluntary drug dependence treatment available in prisons? If yes, what forms of treatment are available?
173. Can prisoners be subject to compulsory treatments (e.g. for drug dependence, HIV-infection, STIs, etc.)? If yes, please include statistical numbers and effectiveness of such treatment (if applicable), especially related to compulsory drug dependence treatment.
174. Are there specialized medical facilities for prisoners with drug and alcohol dependence within the Ministry of Justice or Ministry of Interior? Which documents regulate sentences served in such facilities?
175. What agency has authority to make decision about compulsory treatment for drug dependence in prisons? What documents regulate such treatment?
176. Please describe the duration, procedures and types of compulsory treatment in prisons.
177. Does compulsory treatment for drug dependence affect other rights of prisoners?
178. Are prisoners on compulsory treatment for drug dependence eligible for transfer to facilities with better conditions?
179. What might be the consequences of refusal of compulsory drug dependence treatment?
180. What happens if a prisoner is not able to finish compulsory drug dependence treatment by the time of release from the penitentiary?
181. Can people continue treatment (e.g. for drug dependence, HIV-infection or viral hepatitis) started in the prison after their release from the institution without any interruption? How is this issue regulated? How is information exchanged between the prison and public medical institutions?
182. Is OST available in prisons? Please indicate national legislation that allows for OST in prisons (or can be interpreted as permitting it).
183. Please describe OST or other new programmes of drug dependence treatment in prisons.

HIV-infection and STI

184. Is there compulsory HIV testing for prisoners? If not, are there regulations prohibiting compulsory HIV testing for prisoners?
185. If compulsory HIV testing in prisons exists, is pre- and post-test counselling provided in such cases?

186. Are there regulations on obtaining informed consent for HIV testing before the testing (voluntary testing)? Is counselling provided before and after test?
187. Are there regulations prohibiting compulsory drug use tests for prisoners?
188. Do prisoners with HIV, drug dependence or viral hepatitis have special conditions of employment in prisons? Are there regulations providing employment of prisoners according to their health conditions?

HIV prevention in prisons

189. Is information on HIV transmission and its prevention available in pre-trial detention centres and prisons? If yes, what normative acts regulate such distribution of information? What measures on HIV prevention are conducted by the governmental bodies and agencies in prisons?
190. Can prisoners participate in HIV preventive measures as peer counselors?
191. What HIV preventive measures are provided in prisons? Please fill in the table below. What normative acts regulate HIV prevention measures in prisons?
192. If there is not any regulation that legalizes HIV prevention measures in prisons, can provisions of national legislation be interpreted so as to allow such measures in prisons?
193. Is sterile injection equipment available in prisons? If yes, what regulations legalize availability of such equipment in prisons?
194. Do prisoners have free access to products of personal hygiene (including personal shaver)?
195. Do prisoners have access to sterile tattoo equipment? If yes, what regulations legalize such access?
196. Do prisoners have access to condoms (not only in conjugal visits rooms)?
197. Do prisoners have access to disinfectants?
198. What items are listed as not allowed to possess (for example, the items used for cutting or piercing, watches and etc.)?
199. Are there provisions in national legislation guaranteeing that the prisoners living with HIV are not precluded from participation in the various programmes, activities, entertainment and social events in the prison due to their HIV status?
200. Are there regulations admitting the existence of sexual contacts based on mutual consent in prisons and guaranteeing that such sexual contacts are not a subject to punishment?
201. Are there special provisions regarding protection of prisoners from sexual violence?
202. Is food, clothing, everyday necessity goods and personal hygiene items provided to prisoners free of charge or for money? If these products provided on paid basis, what happens if a prisoner is unable to pay?
203. Can prisoners buy grocery products without limitation on their own money?
204. Do prisoners with HIV have access to improved meal plans in case if they do not have financial means to buy extra grocery products? Are prisoners with HIV allowed to receive additional parcels?
205. Please describe conditions of prisoners with TB held in prisons? Where prisoners with TB get their treatment: in the specialized wards of the health unit or in general hospital?
206. In what cases the prisoners are placed under quarantine (isolation)? Can prisoners with HIV and TB be placed under quarantine (isolation)?
207. Are there provisions in national legislation that legalize distribution of following items or conduct of following measures in prisons:
a) information on HIV;
b) condoms;
c) disinfectants;
d) sterile needles and syringes;
) e) disposable shaving accessories and other items of personal hygiene;
f) voluntary HIV testing with counselling ;
i) OST;
h) other HIV prevention measures.

208. What is included in educational work with prisoners (please include reference to the provisions on national legislation)? Is information on health care and HIV included in such education?
209. Are there pre- and post-release rehabilitation programmes for prisoners? What documents regulate such rehabilitation programmes? What is the main aim of rehabilitation programmes? Do such rehabilitation programmes include assistance to prisoners in employment, housing, adaptation? Do rehabilitation

programmes include social rehabilitation of people who use drugs?
210. Are there any regulatory acts, programmes prohibiting discrimination and stigma based on HIV status in prisons?
211. Are there regular, free programmes on tolerance and HIV prevention education for prisons' staff (issues of discrimination based on HIV status, , HIV preventive measures among prisoners, confidentiality of medical records and HIV status of prisoners, homophobia, humane treatment and etc.)
212. Are there specialized prisons for minors? What are conditions of holding minors with HIV in prisons?
213. If there is compulsory medical treatment for minors in prisons, how such treatment is provided?
214. Are there provisions in national legislation regulating distribution of information on HIV in special prison facilities for minors?
215. Are there any particular provisions/regulations related to special needs of women-prisoners as regards their health in general, prevention of STIs, HIV and HCV and drug dependence treatment? Please list them.
216. Which laws and regulations (or their interpretations) have potential to hamper HIV prevention measures in prisons?
217. Are there laws or regulations providing independent monitoring of prison management and respect for prisoners' rights, including the rights of those with HIV and drug dependence?

Table 7. Medical services in prisons and pre-trial detention centres

Services	Antiretroviral therapy	Prevention, diagnostics and treatment of TB	Prevention, diagnostics and treatment of other STIs	Prevention, diagnostics and treatment of viral hepatitis B and C	Prevention, diagnostics and treatment of drug dependence
Availability for general population					
Availability in pre-trial detention facilities					
Availability in prisons					
Possibility to continue the treatment started before imprisonment					
Possibility to continue uninterrupted treatment after release					
Comments					

Table 8. HIV prevention and care programmes in prisons and pre-trial detention centres

HIV prevention measures	**Availability in prisons (yes or no)**	**Availability in pre-trial detention centres**	**Accessibility (including the body or agency that provides the services)**	**Comments**
Distribution of information related to HIV transmission and its prevention				
Distribution of condoms				
Distribution of personal hygiene items				
Accessibility of disinfectants				
Availability of sterile medical equipment				
Needle and syringe programmes –				
Rehabilitation before release from the prison				
Rehabilitation after release from the prison				
Treatment and care for the people living with HIV, viral hepatitis and TB				
Access to antiretroviral therapy				
Voluntary counselling and testing				
OST				
Other				

VII. Anti-discrimination provisions

218. How does national legislation prohibit discrimination? Does national legislation contain such concepts as direct and indirect discrimination? Have there been any legal cases on discrimination related to HIV-infection or drug dependence (or health status in general)?
219. Is discrimination against people living with HIV and people who use drugs explicitly prohibited under the laws of the country?
220. How does national legislation define "disability"? Does the concept of disability include HIV-infection and drug dependence?
221. What are the mechanisms for obtaining compensation in cases on discrimination? Has there ever been such case?
222. What bodies or agencies are responsible for protection against discrimination?
223. What laws and regulations (including national programmes and acts of the executive bodies) can have a serious impact on the risk of discrimination or stigmatization of drug users or prisoners?
224. Are there any provisions in national legislation against promoting negative images of drug users?
225. Are there organizations of people who use (or have used) drugs?
226. Describe (and enclose) normative acts that can have impact on the capacity of NGOs to work in the field of HIV-infection and drug use in prisons.

APPENDIX 3: TRAINING MODULE

Contents

I. Introduction

One of the tasks of the project entitled *Effective HIV prevention and care for vulnerable populations in Central Asia and Azerbaijan* (2006-2010), implemented by the United Nations Office on Drugs and Crime (UNODC) ,was to provide support to the six participating countries in their work on upgrading national legislation, provisions and standards related to HIV infection, drug use and prisons, in alignment with the relevant UN documents. For this purpose, as described earlier, each of these countries formed a group of experts who analysed and assessed legislation using methods developed by the Canadian HIV/AIDS Legal Network to determine whether or not their legislation adequately provided for accessibility of services for prevention of HIV infection and care for people who use drugs and for prisoners.

To familiarise the experts taking part in the project with international human rights standards, legal principles of HIV prevention and treatment, and general accessibility of health care services for people who use drugs and people in prisons, a five-day training session was held in 2007 at the very start of the project. These training guidelines include basic information presented during that training, as well the teaching methods. The guidelines are aimed to inform interested individuals about the project's methodology and to facilitate implementation of similar projects in the future. Designed for trainers, the guidelines represent a thorough and detailed training scheme on the human rights standards and assessment methods of HIV prevention and treatment regulation in the national legislation.

II. Training goals

The training took place within the framework of technical assistance to the countries in their work on upgrading national legislation and regulatory documents to remove legal barriers hindering access to HIV prevention and treatment services for people who use drugs and for prisoners. The ultimate goal of the review and assessment of legislation was the development of recommendations for proposing amendments to the relevant laws, bylaws and other regulatory documents, and ensuring approval of these amendments by corresponding national structures.

This training was designed for participants representing a multidisciplinary group of experts working in law-enforcement, corrections, public health and other areas dealing with HIV issues.
It was expected that at the end of training the participants would:

- improve their knowledge of international human rights standards related to HIV prevention and treatment for prisoners and people who use drugs;
- familiarize themselves with the contents of the *Model Law on Drugs and HIV/AIDS (2006)*, developed by the Canadian HIV/AIDS Legal Network as a guideline for future legislative reforms;
- gain knowledge and skills for using the Assessment Tool to review national laws and strategic documents related to providing access to HIV prevention and treatment services for prisoners and people who use drugs;
- prepare (or improve) the initial plan and work schedule for reviewing and realigning the national legislation and developing recommendations for its amendment.

III. Basic methodology

How to use these guidelines:
These guidelines are designed as a handbook for those who want to replicate the UNODC's project on assessment of legislation and bylaws related to the issue of accessibility of HIV prevention and care services for prisoners and people who use drugs. These guidelines and the principles used for the structured assessment of legislation can also be used by specialists from other areas related to HIV prevention and care among other population groups. Similar assessment and analysis of legislation and law implementation can be used as a first step towards changing policy and law practices in one or another area. Naturally, in that case, it will be necessary to adapt the training contents and the Assessment Tool.

The structure of the guidelines:
A 5-day training course consists of 8 modules. The modules are structured so that, at the beginning, par-

ticipants learn general principles and paradigms, such as human rights (specifically the right to health), drug control policies, and the need to ensure health care for prisoners. This is followed by the discussion of scientifically justified approaches to HIV- prevention and treatment through the concept of universal access to HIV prevention and treatment services with the focus on the rights and needs of people who use drugs and of prisoners. Such a structure lays the groundwork for the philosophy of further assessment of legislation; specifically it includes identification of legal obstacles preventing access to health care services and social support, which are crucial for efficient HIV prevention and treatment among people who use drugs and people in prisons. A special session is devoted to the usage (and possible adaptation) of the Assessment Tool, which should act as a guideline for experts in their assessment of national legislation.

Each training module comprises a training plan, goals and methods of training, and provides an outline for presentations and recommended exercises and group work. The training sessions consist of presentations and group work. If adapted, the training programme should be optimized for maximum interaction and engagement. Participants should not only gain new knowledge and information about the law, human rights, and HIV prevention and treatment, but also learn to use the acquired knowledge and skills in the process of legislation analysis and the development of a strategic plan for legislative reforms.

Training participants might differ by professional status and previous work experience. Among them there could be lawyers working at state agencies, workers of the prosecutor's office, representatives from law enforcement, correctional institutions, drug control agencies, health care institutions and NGOs. In general, the participants may have legal knowledge, but they might lack adequate experience in using the law in the issues related to HIV prevention and treatment; they may be unfamiliar with the principles and methods of effective evidence-based interventions and may have wrong ideas about the concept of harm reduction related to drug use. Ideally, they would be united in their interest in international law, human rights, issues of humanization of criminal law (with regard to people who use drugs), and penitentiary system reform, including other countries' experiences.

Trainers providing this training should be lawyers with adequate knowledge regarding:
- international law and human rights principles, including the right to health;
- international standards regulating drug control issues;
- UN legal principles related to prisons and other closed settings;
- law enforcement issues in relation to human rights of people who use drugs and of prisoners, including the right to accessibility of effective health care services for HIV prevention and treatment; and
- evidence-based interventions for the prevention and treatment of HIV and drug dependence.

It is recommended to include trainers from NGOs who have direct work experience with prisoners and people who use drugs, as well as staff of international organizations and UN agencies working in the area of HIV and drug use. It is also recommended to involve representatives from state organisations and lawmakers, as it may be exactly these people who will be directly involved in the legislative reform process — from initiation to acceptance of amendments to the laws and/or drafting new laws. It is preferable to have a trainer who is knowledgeable in medicine and drug control policies, who can inform trainees about the difficulties and obstacles that people who use drugs might encounter in accessing HIV prevention and treatment services.

It is recommended to invite representatives from NGOs and communities of people living with HIV, people who use drugs and former prisoners to meet with the trainees and provide first-hand and more comprehensive accounts of the needs and the problems they encounter in getting access to HIV prevention and treatment. These meetings can be scheduled on the third and/or fourth day of training and should include adequate time for questions and discussion.

The essence of this training is interactive learning. Trainers should use various methods and techniques, including brainstorming, discussions, problem-solving exercises (based on specific legislation in the studied area), and group work. The trainers can provide participants materials for independent work, particularly texts of international conventions on drugs; agreements in the area of human rights; international recommendations for HIV and AIDS prevention and treatment for people in prisons and people who use

drugs; as well as excerpts from the relevant legislative acts. (A list of handouts and exercise examples and are shown in Annexes A and C of this Module).

When planning presentations, it is important to allocate sufficient time for questions and answers. The training includes an exercise, which is given in Annex C of this Module. There are also three or four sessions of group work during which the participants discuss new information and learn how to apply the knowledge they gained during the training.

It is expected that by the end of training the participants will be able to assess the legislation and bylaws of their countries using the Assessment Tool, write a report and formulate recommendations on the improvement of legislation introducing changes or amendments into legislative and other regulatory documents.

Equipment for training:
- Laptop computer;
- USB memory sticks;
- Flip charts;
- Highlighters, markers; and
- LCD projector.

IV. Methodical recommendations on conducting the training

Introduction of participants and their expectations:
At the beginning, it is important to give the participants an opportunity to get acquainted with each other and to create a friendly atmosphere in the group. For this purpose, the trainer should ask the participants to introduce themselves and speak about their expectations about the training. This will allow the participants to better acknowledge their own goals and see how these concur with the interests of other participants. This will also help the trainer to understand what he/she should focus on during the training. It is recommended to write down the expectations of every participant so that at the end of the training the participants can perform a self-assessment and decide if their expectations were met It is supposed that participants should be able to identify the general goal of the training — gaining knowledge and skills for assessment of national legislation using standard tools; identification of provisions hindering universal access to HIV prevention and treatment for prisoners and people who use drugs; and laying down recommendations for legislative reform.

If the training is conducted for representatives from different countries with different national legal systems, the presented information should not focus on the specifics of national legal systems. Instead, attention should be paid to international law, specifically human rights intruments and principles and the conventions on drug control. The participants should learn positive experiences of countries that successfully regulate various issues related to prevention and treatment of drug dependence and HIV-infection and provide for accessibility of health care services in prisons.

If the training is conducted for an international group of experts, it might include presentations by national teams on the situations in their own countries. For this purpose, it is recommended to ask national teams in advance to prepare 15–20 minute presentations covering the following subjects: national legislation and law enforcement in the area of drug abuse; legislation in the area of drug dependence treatment; accessibility of health care services in prisons; legislative regulation of harm reduction; and possible obstacles to effective HIV prevention and treatment for vulnerable populations.

If the training is conducted for representatives from one country, it is necessary to invite national lawyers (defence lawyers) who have practical experience in dealing with human rights, working with people who use drugs, and handling cases involving drugs. If possible, it is recommended to invite lawyers from NGOs working in the harm reduction area or providing legal assistance to people living with HIV and to people who use drugs. This will provide the participants with insight into the national legislative system and how laws are implemented/enforced in relation to crimes involving drugs and criminal prosecution of people who use drugs.

Sample of training plan on national legislation:

Day	Subject	Recommendations
3	Administrative and criminal law	Examine the basics of administrative and criminal law and law enforcement practices in the area of drug use, drug possession, incitement of drug use and drug propaganda. The trainer should pay attention to practical aspects.
4	Health law / right to health	Health law practices; legal aspects of drug dependence treatment, including therapy by opiate agonists (substitution therapy – OST); patients' rights; liability in case of medical service denial; liability in case of infecting or putting other people into a risk of HIV-infection; legal background of involuntary/ compulsory treatment. The trainer should speak about whether or not there were instances of criminal cases or criminal procedures initiated in the mentioned areas.
5	Issues related to protection of people who use drugs and people living with HIV	Law and law implementation practices in the area of protection against discrimination. Issues related to the attitudes of law enforcement bodies, judges and prosecutors.

These training sessions should be based on the law implementation practices and include detailed review of the issues mentioned above. It is important to remember that among training participants there might be many lawyers who do not need theoretical basics of the problems discussed. They might be mostly interested in the nuances of law enforcement practices and in the question to what extent existing legislation can obstruct (or facilitate) successful HIV prevention and treatment among prisoners and people who use drugs.

If the majority of participants are NGO workers or specialists in other areas, the training organisers should change the structure of training in accordance with the needs of participants. In other words, if there are many NGO representatives (who most likely are not lawyers), it is advisable to provide more information about legal aspects and about national legal systems, and less information about practical aspects of harm reduction and HIV-related issues.

V. Training modules

Recommended structure of each module:
1. Introduction
2. Presentations, questions and answers and
3. Exercises, group work, discussions.

This training is based on the *Model Law on Drug Use and HIV/AIDS* (www.aidslaw.ca/modellaw) and developed in accordance with the Assessment Tool structure, designed for assessment of legislation and law enforcement practices. For effective time management and for better structuring of presented materials, the training modules do not exactly follow the order of the the Model Law modules. Some of the Model Law modules were not included in the training materials and some were incorporated in other materials. However, we recommend the trainers study thoroughly the Model Law and the Assessment Tool.

Day	**Module**	**Structure**	**Time**
Day 1	Module 1: Model Law and the Assessment Tool	1. Presentation: *Model Law on Drug Use and HIV/AIDS*. International experience[1392] 2. Presentation: Assessment Tool for assessing legislation and law enforcement practices Independent work: familiarisation with the Assessment Tool and the *Model Law on Drug Use and HIV/AIDS* Total time:	1 hour 40 min 50 min 2 hours 30 min
Day 1	Module 2: Human rights standards and harm reduction concept	1 Presentation: What is harm reduction? 2 Presentation: Human rights and drug control policy Discussion: Obstacles for practical implementation of the human rights-based approaches in HIV prevention and treatment among vulnerable populations Total time:	1 hour 1 hour 1 hour 3 hours
Day 2	Module 3: Criminal law issues and international conventions on drugs	1. UN Conventions on drugs 2. Administrative and criminal law issues 3. Exercise: Analysis of hypothetical legislation (see the Annex) Total time:	30 hour 1 hour 2 hours
Day 2-3	Module 4: Drug dependence treatment and other health care services	1 Presentation:Models of drug dependence, principles of organization of drug dependence treatment and human rights standards 2 Presentation: OST and other methods of drug dependence treatment. Group work on Assessment Tool Total time:	1.5 hours 1.5 hours 1 hour 4 hours
Day 3	Module 5: Syringe and needle exchange programmes and premises for supervised drug use	1. Programmes providing sterile syringes and needles 2. Rooms for supervised drug use Discussion: Moral aspects or human rights principles and evidence of effectiveness Total time:	40 min 20 min 2 hours 40 min
Day 4	Module 6: Prisons	Presentation: Health care standards ensuring equality within the correctional system Group work. Task: a) identify 2–3 most serious obstacles for initiating or expanding one of the effective interventions on HIV prevention in prisons;6) suggest 2–3 strategies to overcome these obstacles Total time:	1 hour 20 min 1 hour 20 min 2 hours 40 min.
Day 4	Module 7: Protection from discrimination and greater participation of people living with HIV and people who use drugs in decision making	Presentation: Protection from discrimination and greater participation. Outreach work Discussion with participation of people living with HIV, people using drugs and NGO representatives who work in the field of harm reduction. They should be asked to speak about the real difficulties in getting access to HIV prevention and treatment and discuss in the group ways to overcome these obstacles. Total time :	1 hour 1 hour 2 hours.
Day 5	Module 8: Group work**:** development of a work plan for legislation assessment and priorities setting	Total time: depending on the need.	

1392 Time includes question and answer section.

MODULE 1: Model Law and the Assessment Tool

The first module should introduce the Model Law to the participants and give directions on its use for assessing national legislation and law enforcement practices, and their compliance with international human rights standards; the module should also familiarise the participants with the Assessment Tool.

Presentation 1: Model Law

For this presentation the trainer must thoroughly study the Model Law. The presentation should cover the Model Law provisions and, if possible, some national law provisions to give the participants an idea about effective regulation of issues related to HIV prevention among people who use drugs in other countries.

Presentation 2: Assessment Tool

In this presentation the trainer should speak about the purpose of the Assessment Tool, its structure and the aspects that should be considered in completing the Assessment Tool.

1. Structure of the Assessment Tool.
2. How to identify legislative reform priorities for each specific country using the Assessment Tool.
3. Recommendations on filling in the Assessment Tool; what documents should be included; and who should be interviewed.
4. Report writing and development of legislative reform recommendations. Consultations with the experts.
5. Continuation of work: working with policy makers and informing about the results of legislation assessment.

Task: Study the Assessment Tool and prepare questions

MODULE 2: Human rights standards and harm reduction

This module should introduce the participants to the following issues: what is harm reduction; what is the correlation between harm reduction and human rights; what is the position of international organisations and UN agencies with regard to these issues; and how law regulates the issues of harm reduction and human rights. If the training is intended for participants from the same country, it is necessary to cover the issues of legal regulation of harm reduction programmes within national legislation. It is also necessary to introduce participants to drug control policy that is human rights-based and scientifically justified, as well as HIV prevention-oriented.

For this purpose, in this module we recommend giving two presentations accompanied by discussions.

Recommended issues for presentation **1:** "***What is harm reduction?":***

1. The concept, definition and philosophy of harm reduction related to drug use;
2. Types of interventions included in harm reduction:
   - Programmes providing sterile syringes and needles;
   - OST;
   - Distribution of condoms;
   - Distribution of disinfection materials;
   - Other.

3. Countries using harm reduction approaches .
4. Harm reduction issues in the region and legal regulation of harm reduction in the national legislation.
5. Harm reduction in prisons.

It is recommended to adjust the details of information covered in this presentation to the participant's goals of the training and participants' level of knowledge of this subject.

Recommended issues for presentation **2:** ***Human rights and drug control policy***:

1. Efficient drug control and HIV prevention policy: In this presentation it is recommended to mention the ineffectiveness of an exclusively criminal law approach to the problem of drug abuse and to stress the need to find balance between law enforcement measures and approaches guaranteeing improvement of health status of the population (approaches based on health care priorities).
2. Human rights, right to health and international documents regulating right to health.
3. *If participants represent one country, discuss the issues of public health legislation, the basics of the Health Law and precedents in this area for that country.*
4. International and national documents on HIV and AIDS and human rights.

Discussion: Obstacles for implementation of human rights-based approaches to HIV prevention among vulnerable populations. The Moderator should start this discussion by asking for ideas on the possibility of introducing harm reduction measures through regulation of these issues in the national legislation, and about the obstacles that might occur in this process.

MODULE 3: International drug conventions and criminal law issues

In this module the participants should learn about the international conventions on drugs and the impact of these documents on national legislation with regard to drug-related crimes. We recommend the trainers thoroughly study Module 1 of the *Model Law on Drug use and HIV/AIDS* and all three UN conventions on drugs.

Recommended issues for presentation **1:** ***UN drug conventions***:

1. UN conventions on drugs
2. Legal interpretation: flexibility of the conventions' provisions

Recommended issues for presentation **2:** ***Administrative and criminal law provisions***:

1. Deficiencies of an exclusively criminal law-based approach in the issues of drug abuse.
2. Need for reform and humanisation of the criminal law. Human rights issues and approaches based on public health care and HIV prevention.
3. Humanisation potentials:
   Alternatives to criminal prosecution
   Alternatives to imprisonment
4. Examples from the Model Law and other countries' legislative acts

Exercise:

At the end of this module the participants should be asked to conduct an analysis of the hypothetical legislation. The exercise is based on real country legislations from around the world. The participants should analyse and provide an assessment of the clauses/articles as of their impact on the effectiveness of HIV prevention and public health in general. The legislative provisions in this exercise are taken from the laws of the Russian Federation, Canada, the United States of America and Belarus (see an example of this exercise in the Annex of these Guidelines).

MODULE 4: Drug dependence treatment and HIV prevention

At the beginning of this module the facilitator can briefly repeat the information about the right to health, *International Pact on Economic, Social and Cultural Rights*, and the right to medical services, including drug dependence treatment services stemming from the right to health. In this module it is necessary to give a detailed review of the following issues: drug dependence treatment standards; patients' right to participate in decision-making regarding their treatment and their right to influence the treatment process; treatment methods such as use of long-acting opiate-agonists (or opiate substitution therapy — OST); OST procedures and standards; and importance of OST in HIV prevention among people dependent on opiates.

If the training participants represent one country, it is important to review the drug dependence treatment standards in that country as well as the procedures and rules of providing OST (including OST accessibility and its coverage).

Plan of the presentations:

1) What ways human rights standards, especially those related to the right to health, can be applied in the field of drug dependence treatment.

2) How to measure OST accessibility and treatment quality (service provision standards and clinical protocols). For participants from countries without legal provisions for OST, it is important to draw their attention to the fact that UN agencies recommend OST as one of the most effective measures of HIV prevention and treatment of opiate drug dependence. It is recommended to provide a review of other countries' legal regulations about OST accessibility.

3) Other methods and standards of drug dependence treatment; legal regulation of these methods and standards.

Group work on the Assessment Tool:
In this exercise the participants break into thematic groups to discuss various issues related to the Assessment Tool, e.g. access to medical services. The groups should discuss the following issues: a) what documents should be included in the assessment; b) what groups of people should be interviewed for obtaining additional information; c) what issues require special attention.

MODULE 5: Needle and syringe programmes and supervised drug consumption facilities
This module covers two types of harm reduction interventions. The most popular and widely employed harm reduction method is the provision of sterile syringes and needles. The premises or institutions for supervised drug consumption are less widely employed, but according to the statements of international organisations, they do not contradict international law or standards.

Presentation 1: Sterile needle and syringe programmes
1. Goals and tasks of syringe exchange/distribution. Methods of syringe distribution.
2. International documents legalising programmes providing sterile injection instruments. Regulation of the programmes providing sterile injection instruments in the national legislation (if the training is conducted for representatives from a single country).
3. Model Law Module 3 on sterile injection instruments.

Presentation 2: Supervised drug consumption facilities
1. Importance of availability of supervised drug consumption facilities.
2. International documents on legality of these institutions.
3. Model Law Module 4 on supervised drug consumption facilities.

The information provided should introduce participants to large-scale HIV prevention strategies for people who inject drugs. Supervised drug consumption facilities exist in a number of countries; however this approach is still controversial. This training recommends introduction of such strategies only with careful consideration of the specific political and social environment in the country in question.

Discussion: Harm reduction: "Moral" considerations vs. human rights principles and the evidentiary effectiveness.

The discussion can begin from a review of such a controversial approach as an opening of safe drug use facilities. In many countries, there are people who believe that intimidation and punishment are effective means of decreasing drug use levels and consequently the risk of HIV-infection. This approach implies the requirement of immediate termination of illegal drug use. How realistic are these requirements? According to WHO, drug dependence is a chronic disease, and people who use drugs should not be automatically counted as offenders who lose their rights — they have the same rights and protections as everybody else. It is necessary to stress not only the human rights component but also the public health aspects of this issue. To what extent does the current prohibitionist policy towards people who use drugs promote public health and social well being? Is it effective?

MODULE 6: HIV prevention and treatment in the correctional system
This module is designed to introduce participants to the HIV prevention and treatment measures in the correctional institutions. The details of this presentation can vary depending on the participants' knowledge level and their interests. The concept of "prisons" in this document embraces all institutions of the correctional system, including colonies and temporary detention centres.

Plan of the presentation:
1. The risk of HIV-infection spread in prisons: Why is it important to introduce harm reduction approaches in prisons?
2. Rights of prisoners: Prisoners and people detained in temporary detention centres are deprived of freedom while enjoying all other rights. They must have access to the same level of medical care available to the general population.
3. Morbidity statistics: HIV-infection, TB, hepatitis, STIs, mental disorders, gender differences.
4. Prevention of HIV-infection and associated diseases at correctional institutions.

If the training participants represent a single country, it is recommended to familiarise them with the situation related to HIV-infection prevalence and the approaches to prevention of HIV-infection and associated diseases within that country's correctional system.

Group work: The participants break into 6 groups. The theme of discussion: "Health care in prisons: legal and regulatory aspects."
Task: a) define 2–3 of the most serious obstacles for initiating or increasing the scale of one of the six effective interventions (below) on HIV-infection prevention in prisons;b) offer 2–3 strategies that will help to overcome these obstacles.

Thematic groups: 1) Syringe distribution/exchange programmes; 2) Opiate substitution therapy and other drug dependence treatment methods; 3) STIs and condoms; 4) Voluntary counselling and HIV testing; 5) treatment and support of people living with HIV ;
5) Viral hepatitis and TB; 6) Prevention of violence , especially as regards sexual violence.

MODULE 7: Protection against discrimination and greater participation in decision making of people living with HIV and people who use drugs
In this module's presentation it is recommended to discuss an important issue of human rights guarantees, for example, protection against discrimination. Discrimination against people living with HIV and people who use drugs manifests in different ways (provide the definitions of discrimination and stigmatization and provide examples). The theme of greater participation in decision making of people living with HIV and people who use drugs is integrated with the theme of protection against discrimination, because participation is one of our human rights and a form of self-protection of one's own rights. In this module it is also necessary to discuss the theme of outreach work conducted by former or current drug users and to stress the greater effectiveness of such work versus similar activity conducted by medical workers or people who do not have personal experience in drug use.

Presentation:
1. The concepts of discrimination, vilification and stigma.
2. How to address discrimination and stigmatization. UN documents and legal protections.
3. Greater involvement of people living with HIV and people who use drugs in decision making.
4. Outreach work.

Discussion with the participation of people living with HIV, people who use drugs, and NGO representatives active in the area of harm reduction. Encourage them to speak about real life difficulties in accessing HIV prevention and treatment services that they encounter and discuss the ways for overcoming these obstacles.

MODULE 8: Planning activities for legislative review, assessment and reform
On the last day of training it is recommended to work in small groups to plan further activities for improving access to HIV prevention and treatment services for prisoners and people who use drugs. The group work should focus on reaching the final goal of the training. It should be based on the participants' expectations. If the final goal of the training includes legislation assessment (as in the case presented in these guidelines), it is necessary to plan on the last day the activities for reaching this goal. If the final goal is different, then it is necessary to plan the activities in accordance with that goal (creation of a professional group or network of organizations, development of strategic plan, etc.).

Tasks for the group work:

- discuss the directions and focus of the country's legislative modernisation; define reform priorities (pursuant to the Assessment Tool);
- discuss possible difficulties and describe ways for overcoming these difficulties;
- agree on coordination mechanism among the team participants (groups of experts) and define the time frames for the activities;
- prepare presentations based on the results of the group work.

CONCLUSION: By the end of training it is necessary to analyse the training process and its results; formulate lessons learned; analyse successes and deficiencies; and prepare a training report. Based on participants' feedback (using the training assessment questionnaire) identify their needs in the future work on reforming legislative systems. Participants may request additional materials and ask for additional trainings, seminars, round table discussion, etc. It is necessary to keep in touch with the participants on a regular basis and coordinate their future activity in reforming legislative systems and law implementation in the area of HIV prevention and care.

ANNEX A: LIST OF DOCUMENTS USED IN TRAINING

1. Office of the UN High Commissioner for Human Rights and UNAIDS, *International Guidelines on HIV/AIDS and Human Rights* (2006 Consolidated Version), online: http://data.unaids.org/Publications/IRC-pub07/JC1252-InternGuidelines_en.pdf.

2. *Taking Action Against HIV: A Handbook for Parliamentarians* (Handbook No. 15) (UNAIDS, UNDP and Inter-Parliamentary Union, 2007), online: http://www.ipu.org/English/handbks.htm#aids07

3. UN General Assembly, Declaration of Commitment on HIV/AIDS (2001), online: http://www.unaids.org/en/AboutUNAIDS/Goals/UNGASS/default.asp

4. Preventing the transmission of HIV among drug abusers: A position paper of the United Nations system (2002), online: http://www.aidslex.org/site_documents/J036E.pdf or http://www.cicad.oas.org/en/Resources/UNHIVaids.pdf

5. *WHO/UNODC/UNAIDS position paper: Substitution maintenance therapy in the management of opioid dependence and HIV/AIDS prevention* (2004), online: http://www.who.int/hiv/pub/idu/position_paper_substitution_opioid/en/index.html

6. UN Drug Control Programme (Legal Affairs Section), *Flexibility of treaty provisions as regards harm reduction approaches (Decision 74/10)* (2002), online: http://www.aidslex.org/site_documents/Z121E.pdf.

7. WHO Guidelines on HIV infection and AIDS in prisons, WHO/GPA/DIR,93.3 (1993), online: http://www.who.int/hiv/idu/WHO-Guidel-Prisons_en.pdf

8. UNODC, WHO & UNAIDS, AIDS prevention, care, treatment and support in prison settings: a framework for an effective national response (2006), online: http://www.who.int/hiv/pub/idu/prison_framework/en/index.html.

9. Canadian HIV/AIDS Legal Network, HIV/AIDS in Prisons in Central and Eastern Europe and the former Soviet Union (2006), online: http://www.aidslaw.ca/publications/publicationsdocEN.php?ref=174.

10. R. Lines et al., *Prison Needle Exchange: Lessons from a Comprehensive Review of International Evidence and Experience (2nd ed.)* (Canadian HIV/AIDS Legal Network, 2006), online: http://www.aidslaw.ca/publications/publicationsdocEN.php?ref=184.

11. Canadian HIV/AIDS Legal Network, "Opioid Substitution Therapy in Prisons: Reviewing the Evidence" (2008), online: http://www.aidslaw.ca/publications/publicationsdocEN.php?ref=163

Documents produced by the Canadian HIV/AIDS Legal Network are available on its website at www.aidslaw.ca (search under "Publications").

ANNEX B: SAMPLE TRAINING PROGRAMME

Day 1

9.00 Registration

9.30 Opening. Practical issues and a work plan

10.00 Introduction of the participants, their expectations and areas of interest

1.45 Framework and the goal of training. Tasks and expected training results

11.00 Coffee break

11.20 Information about the project. Drug control policy and universal access to HIV- prevention and treatment: UNODC strategies

11.50 Module 1: Model Law and international law
Questions

12.50 Module 1: Assessment Tool and recommendations on its use and application
Questions

13.30 Lunch

14.30 Module 2: Harm reduction
Questions

15.30 Coffee break

15.45 Module 2: Human rights and harm reduction
Questions

16.40 General discussion: Obstacles for implementation of the human rights-based approaches in the process of HIV prevention and treatment among vulnerable populations

17.30 Closure of the first day's sessions

Task: Study the Assessment Tool and prepare questions

Day 2

9.00 Review of the previous day's themes

9.10 If training participants represent different countries, they give presentations about the situation in their countries (15–20 min for each country)[1393]

11.00 Coffee break

11.20 Continuation of presentations

13.00 Lunch

1393 If training participants represent one country the facilitator should conduct a training session on Modules 2 and 3 followed by the session devoted to legal regulation of these issues in the national legislation.

14.00 Module 3: International conventions on drugs
Questions

15.00 Module 3: Criminal law issues
Questions

15.45 Coffee break

16.00 Work in groups (country groups or groups formed based on other criteria: exercise on analysis of hypothetical legislation

16.45 Group presentations on analysis of hypothetical legislation (5 min. for each group)

17.30 Closure of the second day's sessions

Day 3

9.00 Review of the previous day's sessions

9.20 Module 4: Drug dependence treatment
Questions and answers

10.30 Group work on Assessment Tool (treatment accessibility, testing for HIV and drugs, and OST, etc.) thematic groups:
a. what documents should be included in the assessment?
b. what groups of people should be interviewed for obtaining additional information?
c. what issues should be taken into consideration during implementation of legislative/normative documents?

11.30 Coffee break

11.50 Presentation of the results of group work (10 min. each)

13.00 Lunch

14.00 Module 5: Syringe exchange programmes
Questions and answers

14.40 Module 5: Medically supervised drug use facilities
Questions and answers

15.00 Coffee break

15.20 Discussion: Apprehensions and moral considerations vs. human rights principles and evidence of effectiveness

16.00 Closure

Day 4

9.00 Review of the previous day's sessions

1.10 Module 6: Prisons
Questions and answers

10.30 Group work (country groups or groups formed based on other criteria): Health issues in prisons: legal

and normative aspects
Task:
a) define 2–3 of the most serious obstacles for initiation or expansion of one of the effective interventions on HIV-infection prevention in prisons;
b) offer 2–3 strategies for overcoming these obstacles.

Thematic groups : 1) Syringe distribution/exchange programmes; 2) OST and other drug dependence treatment methods; 3) STIs and condoms; 4) Voluntary counselling and testing; 5) Care and support for PLHIV; 5) Viral hepatitis and TB; 6) Prevention of violence, especially sexual violence.

11.30 Coffee break

11.50 Group reports

13.00 Lunch

14.00 Module 7: Anti-discriminatory provisions and greater participation of people living with HIV and people who use drugs in decision making

15.00 Coffee break

15.20 Meeting with organisations of people who use drugs and/or with people living with HIV or the organisations providing harm reduction services. Discussion

17.00 Closure

Day 5

9.00 Review of the previous day's sessions

9.10 Group work (country groups)
Task:
- Discuss the countries' main challenges and needs and define reform priorities (pursuant to the Assessment Tool);
- Discuss and describe possible difficulties and the ways for overcoming those difficulties;
- Develop a strategic plan for further activities;
- Agree on coordination mode between the team members (groups of experts) and define adequate time frames for the activities;
- Prepare a presentation

11.00 Coffee break

11.20 Continuation of group work

12.00 Group presentations
Questions

13.00 Lunch

14.00 Group presentations (continuation)
Questions and answers

15.15 Training results

15.30 Training assessment (filling in the assessment form)

15.45 Closure of the training

ANNEX C: LEGISLATIVE ANALYSIS EXERCISE

Exercise
Please familiarise yourself with the following excerpts from legislation of country X, and prepare a short analysis of its compliance with international human rights norms. Please indicate positive and negative features, and which provisions should be amended or reviewed.

1. **[X] Federal Act on narcotic drugs and psychotropic substances**

....
Article 2. Schedule of narcotic drugs, psychotropic substances and their precursors controlled in [X]

1. Narcotic drugs, psychotropic substances and their precursors controlled in [X] shall be included in the Schedule of narcotic drugs, psychotropic substances and their precursors controlled in [X] and, depending on the control measures applied by the State, shall also be included in the following lists:

- List of narcotic drugs and psychotropic substances whose trade is prohibited in [X] pursuant to its legislation and to the international agreements to which it is party (hereinafter referred to as "List I")
[NB. Methadone listed under List I]

- List of narcotic drugs and psychotropic substances whose trade in [X] is restricted and in respect of which control measures are established pursuant to the legislation of [X] and to the international agreements to which it is party (hereinafter referred to as "List II");
[NB. Buprenorphine listed under List II]

- List of psychotropic substances whose trade in [X] is restricted and in respect of which exemptions are permitted from certain control measures pursuant to the legislation of [X] and to the international agreements to which it is party (hereinafter referred to as "List III");

- List of precursors whose trade in [X] is restricted and in respect of which control measures are established pursuant to the legislation of [X] and to the international agreements to which it is party (hereinafter referred to as "List IV").

....

Article 31. Use of narcotic drugs and psychotropic substances for medical purposes

6. In [X] the use of narcotic drugs and psychotropic substances included in List II for the treatment of drug dependence shall be prohibited.

2. **Criminal Code X**

Article 230. Inducement to Use Narcotic Drugs or Psychotropic Substances Inducement to use narcotic drugs or psychotropic substances shall be punishable by restraint of liberty for a term of up to three years, or by arrest for a term of up to six months, or by deprivation of liberty for a term of two to five years.

3. **The Model Drug Paraphernalia Act**

Article I

The term 'drug paraphernalia' means all equipment, products and materials of any kind which are used, intended for use, or designed for use, in planting, propagating, cultivating, growing, harvesting, manufacturing, compounding, converting, producing, processing, preparing, testing, analyzing, packaging, repackaging, storing, containing, concealing, injecting, ingesting, inhaling, or oth-

erwise introducing into the human body a controlled substance in violation of this Act (meaning the Controlled Substances Act of this State). It includes, but is not limited to:

…
(11) Hypodermic syringes, needles and other objects used, intended for use, or designed for use in parenterally injected controlled substances into the human body.
….

Article II

Section (A) Possession of Drug Paraphernalia
It is unlawful for any person to use, or to possess with intent to use, drug paraphernalia… Any person who violates this section is guilty of a crime and upon conviction may be imprisoned for not more than (), fined not more than (), or both.

Section (B) Manufacture or Delivery of Drug Paraphernalia
It is unlawful for any person to deliver, possess with intent to deliver, or manufacture with intent to deliver, drug paraphernalia… Any person who violates this section is guilty of a crime and upon conviction may be imprisoned for not more than (), fined not more than (), or both.

4. **Controlled Drugs and Substances Act**

Article 2:
(2) For the purposes of this Act,
(a) a reference to a controlled substance includes a reference to any substance that contains a controlled substance; and
(b) a reference to a controlled substance includes a reference to
(i) all synthetic and natural forms of the substance, and
(ii) any thing that contains or has on it a controlled substance and that is used or intended or designed for use
(A) in producing the substance, or
(B) in introducing the substance into a human body.

Article 4: (1) Except as authorized under the regulations, no person shall possess a controlled substance included in Schedule I, II or III.

In the Russian version of the report more legislative examples are given, i.e. related to criminal justce (prisons)

ANNEX D: EVALUATION OF TRAINING SESSION

Participant questionnaire

1. How would you assess the training quality in general?
☐ excellent ☐ good ☐ satisfactory ☐ unsatisfactory

2. To what extent do you think the training achieved its goals?

☐ excellent ☐ good ☐ satisfactory ☐ unsatisfactory

3. Please assess the programme of the trainings
☐ excellent ☐ good ☐ satisfactory ☐ unsatisfactory

4. Please assess the way the training was carried out?
☐ excellent ☐ good ☐ satisfactory ☐ unsatisfactory

5. How useful for you was the group work?
☐ excellent ☐ good ☐ satisfactory ☐ unsatisfactory

6. Please assess the quality of materials presented before and during the training
☐ excellent ☐ good ☐ satisfactory ☐ unsatisfactory

7. What was the most *useful* part of training for you?

_____

_____

_____

8. What was the *least* useful part of training for you?

_____

_____

_____

_____

9. Did the training improve your knowledge about HIV prevention among people who inject drugs?
☐ Yes ☐ No

10. Did the training improve your knowledge about HIV prevention in the correctional system?
☐ Yes ☐ No

11. Did the training improve your knowledge in the area of international human rights standards?
☐ Yes ☐ No

12. Did the training improve your knowledge about legislative regulation of HIV prevention measures?
☐ Yes ☐ No

_____

_____

_____

13. What sort of additional information would you like to receive to assist your work in upgrading legislation in the area of HIV prevention and treatment among prisoners and people who use drugs?

_____
_____
_____
_____

14. If you need technical assistance please indicate in which area:

_____
_____
_____
_____

15. Additional commentaries and suggestions:

_____
_____
_____
_____

Thank you very much for taking time and filling in this questionnaire. Your answers will help us in planning future activities. Please rest assured that this information will be used confidentially.

APPENDIX 4

Checklist for country's self-assessment of conformity of national legislation to international human rights standards

This checklist of 100 questions provides a tool for countries to rate their progress on reforming or implementing laws, policies and practices so as to strengthen HIV prevention, care, treatment and support for people who use drugs and in prisons.

Note: In the questions on this list, the term "law" is used broadly to include not only statutes but any other, subsidiary forms of legally-binding rules promulgated by government authorities, such as regulations, orders, decrees and instructions.

Please tick the box only if the answer to the question is "yes".

National programmes and strategies

Ensuring national strategies address HIV- infection among vulnerable groups **YES**

1. Does the national programme/strategy on HIV specifically include measures for HIV prevention and treatment for people who use drugs? ☐
2. Does the national programme/strategy on HIV specifically include measures for HIV prevention and treatment for prisoners? ☐
3. Does the national programme/strategy on drugs contain provisions on harm reduction? ☐
4. Does the national programme/strategy on drugs require that people have access to voluntary treatment for drug dependence? ☐

Education and stigma reduction

5. Are there legal acts, plans or strategies ordering regular training for law enforcement bodies on the prevention of HIV-infection among vulnerable groups, including people who use drugs and prisoners? ☐
6. Are there legal acts, plans and strategies providing for including in the education of health care workers training on HIV-infection, including training on HIV prevention and other harm reduction measures among vulnerable groups such as people who use drugs and prisoners? ☐
7. Do programmes and strategies include measures to address stigmatizing attitudes and coverage by the mass media in relation to HIV-infection and people living with HIV? ☐
8. Do programmes and strategies include measures to address stigmatizing attitudes and coverage by the mass media in relation to people who use and/or are dependent on drugs? ☐
9. Do programmes and strategies include measures to address stigmatizing attitudes and coverage by the mass media in relation to prisoners? ☐

Financing of programmes and strategies

10. Does the national programme/strategy on HIV include a budget and directives for financing the measures in the programme/strategy? ☐
11. Does the national programme/strategy on drugs include a budget and directives for financing the measures in the programme/strategy? ☐

Ensuring HIV prevention and treatment in prisons

12. Is there a national plan on reforming the correctional system that includes, among other objectives, ensuring that the correctional system complies with human rights standards and good practices for health protection and promotion? ☐

13. If there is such a plan, does it include measures for HIV prevention in prisons and pre-trial detention centres and for medical treatment for people tested HIV-positive in such settings? ☐

14. Does this plan include measures to ensure access to voluntary treatment for drug dependence while imprisoned? ☐

15. Does this plan on reforming the correctional system include a budget and directives on financing the measures in the plan? ☐

Monitoring and evaluation

16. Does either national law or the national programme/strategy on HIV provide for assessment of the effectiveness of the programme/strategy in preventing HIV infection and promoting access to HIV-related care, treatment and support? ☐

17. Does either national law or the national programme/strategy on drugs provide for assessment of the effectiveness of the drug programme/strategy? ☐

18. Does either national law or the national plan on the correctinal system provide for assessment of of the effectiveness of the plan? ☐

Involvement of persons living with HIV and vulnerable groups in the national response

19. Does the national law or the national programme/strategy on HIV include any measures for ensuring the involvement of people living with HIV in the development, implementation and evaluation of programmes on HIV/AIDS? ☐

20. Does the national law or national programme/strategy on drugs include any measures for ensuring the involvement of people who formerly used or currently use drugs in the development, implementation and evaluation of programmes for preventing and treating drug dependence, and for preventing and treating HIV-infection among people who use drugs? ☐

Criminal and administrative law issues

Depenalizing people who use drugs and mitigating harshness of legal penalties

21. Has the country abolished criminal liability for the mere consumption of drugs? ☐

22. Has the country abolished administrative liability for the mere consumption of drugs? ☐

23. Has the country abolished criminal liability for possession of small quantities of narcotic substances without intent to sell (i.e. for personal consumption)? ☐

24. Does the law provide for directing a person with drug dependence into treatment rather than imposing a criminal sentence for offences which do not represent a grave public danger? ☐

25. Does the law generally allow for alternatives to imprisonment in sentencing for non-violent criminal offences related to drugs (e.g. fines, treatment orders, deprivation of certain rights short of imprisonment)? ☐

26. Has the country abolished legislative provisions defining being intoxicated during the commission of a criminal or administrative offence as an aggravating circumstance resulting in a harsher sentence? ☐

Avoiding legal liability for harm reduction programmes and workers

27. Does the law provide that staff and volunteers of harm reduction programmes, which distribute educational materials and materials (e.g., sterile needles or other drug use equipment) for use in reducing HIV transmission and other risks of harm to people who use drugs, are protected against criminal prosecution and liability (e.g., for drug "propaganda" or "inducement to drug consumption", possession of illegal drugs based on drug residue on used equipment, etc.)? ☐

28. Does the law provide that harm reduction programmes (e.g., needle and syringe programmes), which distribute educational materials and materials for use in reducing the risks of harm (inluding HIV transmission) associated with drug use, are exempt from administrative liability (e.g., for drug "propaganda" or "inducement to drug consumption")? ☐

Abolishing criminal and administrative liability of groups vulnerable to HIV and human rights abuses

29. Has the country abolished criminal liability for prostitution (not involving coercion or human trafficking)? ☐

30. Has the country abolished administrative liability for prostitution (not involving coercion or human trafficking)? ☐

31. Has the country abolished criminal liability for homosexual activity between consenting partners? ☐

32. Has the country abolished administrative liability for homosexual activity between consenting partners? ☐

33. Has the country abolished criminal and administrative liability for STI exposure and non-intentional STI transmission? ☐

34. Has the country abolished criminal and administrative liability for HIV exposure and non-intentional HIV transmission? ☐

Limiting compulsory testing and treatment

35. Has the country abolished compulsory drug testing of persons in cases where the person has not committed any illegal act but is merely "suspected" of using drugs? ☐

36. Has the country abolished administrative liability for evading drug testing? ☐

37. Has the country abolished administrative liability for evading treatment for drug dependence? ☐

38. Has the country abolished administrative liability for evading testing for HIV or other STIs? ☐

39. Has the legislation abolished administrative responsibility for evading treatment for HIV or other STIs? ☐

Health services

40. Has the country removed HIV infection and AIDS from the list of "diseases representing a danger to the public" / "socially significant diseases" (or other similar list)? ☐

41. Has the country removed drug dependence from the list of "socially significant diseases" (or other similar list)? ☐

Treatment for drug dependence

42. Are there any national standards for treatment of drug dependence that have been adopted by a state body? ☐

43. Has the law limited the use of compulsory treatment of drug dependence to narrow circumstances such as those in which a person poses a *significant risk of serious harm*[1394] to himself/herself or others? ☐

44. If the law provides for compulsory treatment of drug dependence in the case of a person convicted of an administrative offence, is treatment an alternative to imposing some other administrative penalty? ☐

45. If the law provides for compulsory treatment of drug dependence in the case of a person convicted of a criminal offence, is treatment an alternative to imposing some other criminal sentence? ☐

46. If the law provides for compulsory treatment of drug dependence, does the law provide an accessible means of challenging alleged infringements of rights in the course of compulsory treatment that takes place outside of correctional institutions (e.g., in "treatment-labour" camps or similar facilities)? ☐

47. If the law provides for compulsory treatment of drug dependence, does the law provide an accessible means of challenging alleged infringements of rights in the course of compulsory treatment that takes place inside correctional institutions? ☐

48. Does the law mandate that the state ensure the availability of a full range of services for treatment of drug dependence (e.g., detoxification, rehabilitation, etc.)? ☐

49. Does the law specifically mandate the provision of opioid substitution treatment (OST) as one element of a comprehensive approach to treatment for drug dependence (and as an important element of HIV prevention and treatment among people who use drugs)? ☐

50. Is methadone included in the list of substances authorized for use in medical practice, and in particular, for use in treatment of opioid dependence? ☐

51. Is buprenorphine included in the list of substances authorized for use in medical practice, and in particular, for use in treatment of opioid dependence? ☐

52. Is methadone included in the national list of essential medicines? ☐

53. Is buprenorphine included in the national list of essential medicines? ☐

54. Does the law address the need for programmes of drug dependence treatment that consider the needs of women (e.g., staying with children), including pregnant women? ☐

55. If people with the resources can pay for drug dependence treatment that is fully anonymous, does the law also provide for free access, for those who cannot pay, to treatment that is anonymous (i.e., that does not require the person to provide his or her full name or other identifying information)?[1395] ☐

1394 See the glossary in Appendix 5 for an explanation of the term *significant risk of serious harm*.

1395 See the glossary in Appendix 5 for an explanation of the difference between "anonymous" and "confidential" health services.

56. Has the country abolished the registration of people who use and/or are dependent on drugs? ☐

57. If a drug user registry exists, does the law protect the confidentiality of patients, allowing the disclosure of confidential patient information only in very limited circumstances? In particular, has the law been amended to remove broad provisions that permit or require reporting of overdose cases to police or other disclosure of patient information to law enforcement authorities simply upon request by those authorities? ☐

HIV and STI testing and treatment

58. Does the law require pre-test and post-test counselling, including in cases of involuntary testing? ☐

59. Does the law require that a patient give informed consent in writing to an HIV test? ☐

60. Involuntary HIV testing should be limited to (i) those donating blood, organs or other tissues or bodily samples, and (ii) in other cases, by court order only. Does the law limit involuntary HIV testing to these situations? ☐

61. Has the country abolished involuntary/compulsory HIV testing simply on the basis that a person is suspected of being HIV-positive? ☐

62. Has the country abolished involuntary HIV testing of people who use (or are thought to use) drugs? ☐

63. Has the country abolished involuntary HIV testing of sex workers (or people perceived to be engaged in sex work)? ☐

64. Has the country abolished involuntary HIV testing of prisoners? ☐

65. Does the law mandate the availability of free testing for HIV and other STIs that is anonymous (i.e. that does not require the person to provide his or her full name or other identifying information)? ☐

66. Does the law provide for the possibility of free anonymous treatment for STIs? ☐

HIV prevention among people who use drugs: harm reduction services

67. Does the law include any provisions specifically mandating the availability of HIV prevention measures for people who use drugs? ☐

68. Does the law explicitly mandate the implementation of needle and syringe programmes as part of HIV prevention measures for people who use drugs? ☐

69. Does the law include any provisions directing law enforcement authorities to facilitate the work of harm reduction programmes (or at least abstain from interfering with the work of those programmes)? ☐

70. Does the law include any provisions clearly outlining the responsibilities of outreach workers of harm reduction programmes? ☐

71. Does the law allow (or at least not prohibit) people who use drugs to work in programmes on HIV prevention (e.g., as outreach workers)? ☐

Patients' rights, including confidentiality

72. Does the law impose a *working* obligation to maintain the confidentiality of personal information (including health information such as HIV status or drug use or dependence) obtained in the course of providing health services, and impose liability for breaching confidentiality without legal authorization? ☐

73. Does the law explicitly outline the rights of patients in the context of receiving health services, including the right to participate in determining methods of treatment, to terminate treatment, and to mechanism for patients to seek redress for violations of rights? ☐

Discrimination and other restrictions of rights

74. Is there a state body whose functions include protection against discrimination, including on the basis of health? ☐

Discrimination against people living with HIV

75. Does the law forbid HIV testing for general purposes connected with employment or enrolment in an educational programme? ☐

76. Has the country abolished rules prohibiting persons with HIV from adopting a child based on HIV status? ☐

77. Has the country abolished discriminatory restrictions of the rights of persons living with HIV (e.g.,work in health care, food sector, the military, educational institutions, etc.)? ☐

78. Has the country abolished rules prohibiting persons with HIV from receiving a visa or entering the country? ☐

79. Has the country abolished rules that prohibit a person with HIV from remaining in the country or that provide for the deportation of a person based on HIV-positive status? ☐

Discrimination against people who use drugs

80. Does the law prohibit involuntary drug testing at a workplace or in educational institutions except in very limited circumstances and on a case-by-case basis? ☐

81. In proceedings involved alleged child abuse or neglect, or situations giving rise to concerns that a child may be at risk of abuse or neglect, does the law make it clear that determinations of parental rights should be made based on individual assessments of what is in the best interests of a child, and is there a clear direction to adjudicators that such decisions should not be based on inaccurate, generalized assumptions about a person's incapacity to be a suitable parent because of his or her use of or dependence on drugs? ☐

82. Has the country abolished rules requiring prospective students to present a certificate proving they are not on the drug user registry before enrolment in educational institutions? ☐

83. Has the country abolished rules according to which a person's drug use *per se* is sufficient to bar the person from receiving a visa or entering the country? ☐

Access to social benefits based on disability

84. Does the law contain provisions granting physical disability status to persons with HIV-infection and/or an AIDS diagnosis? ☐

85. Does the legislation contain provisions for granting physical disability status to persons with drug dependence? ☐

Prisons

86. Does the law include any provisions specifically mandating that state bodies must institute HIV prevention measures in prisons? ☐

87. Does the law specifically mandate that condoms be freely available in prisons? ☐

88. Does the law specifically mandate that disinfectants be freely available in prisons? ☐

89. Does the law specifically mandate that sterile needles and syringes be freely available in prisons? ☐

90. Does the law specifically mandate the distribution to prisoners of information on HIV and ways to protect against HIV infection? ☐

91. Does the law specifically mandate the distribution to prison system staff of information on HIV and ways to protect against HIV infection? ☐

92. Does the law specifically preserve the confidentiality of prisoners' health information, including HIV status and drug use or dependence? ☐

93. Does the law mandate that the same range and quality of health services be available to prisoners as are available to people outside prisons? ☐

94. Does the law mandate access to antiretrovrial (ARV) therapy for prisoners with HIV? ☐

95. Does the law mandate access to voluntary treatment for drug dependence for prisoners? ☐

96. Does the law mandate access to opioid substitution treatment (OST) for prisoners? ☐

97. Does the law mandate that prisoners have access to sterile needles and syringes as are available outside prisons? ☐

98. Does the law contain provisions that can be used to ensure that prisoners with compromised immune systems, including prisoners with HIV, have access to adequate nutrition? ☐

99. Has the country abolished discriminatory measures in relation to prisoners with HIV infection or with drug dependence, such as segregation of prioners testing HIV-positive or prohibition on being transferred to institutions with less harsh living conditions? ☐

100. Does the law allow non-governmental organizations (NGOs) to do HIV prevention and support work in prisons? ☐

APPENDIX 5

Glossary of terms

Note: Many of the entries in this glossary are taken from the following UN terminology guides and glossaries: UN Office for Drug Control and Crime Prevention, Demand Reduction: A Glossary of Terms (2000); UNAIDS, Terminology Guidelines (2008); UNODC, Drug Abuse Treatment and Rehabilitation: A Practical Planning and Implementation Guide (2003). In some cases, some entries have been adapted slightly from the original source.

Abstinence
The term refers to the act of refraining from alcohol or other drug use, whether for health, personal, religious, moral, legal or other reasons.

Agonist
A substance that acts on receptor sites to produce certain responses. For example, both methadone and heroin are agonists for opioid receptors.

Alternatives to imprisonment
The imprisonment of people on charges relating to their personal drug use is problematic from the perspective of HIV prevention. Drugs are usually available in prisons, but often people in prison have no or limited access to opioid substitution treatment (e.g. methadone, buprenorphine) and sterile injecting equipment, which increases the risk of transmission of blood-borne diseases such as HIV infection and hepatitis. This makes prisons a high-risk environment for HIV transmission and other drug-related harms, and policies that perpetuate the incarceration of people who use drugs exacerbate the spread of HIV. Alternatives to imprisonment include such measures as administrative sanctions instead of criminal incarceration, court diversion after or before charges, and the use of non-custodial punishments if sentenced.[1396]

Antagonist
A substance that counteracts the effects of another agent. Pharmacologically, an antagonist interacts with a neuronal receptor to inhibit the action of agents (agonists) that produce specific physiological or behavioural effects mediated by that receptor. For example, naloxone is an antagonist that rapidly blocks opioid receptors, making it useful for quickly counteracting overdoses of opioids such as heroin.

Blood-borne virus
A virus which can be transmitted from an infected person to another person by blood-to-blood contact, such as through blood transfusion or the sharing of injecting equipment or other skin-piercing equipment (e.g., for tattooing). HIV, hepatitis B virus (HBV) and hepatitis C virus (HCV) are blood-borne viruses.

Buprenorphine
A semi-synthetic substance that has partial agonist and partial antagonist functions, which can be used in opioid substitution treatment. It has also been used extensively in many countries for the short-term treatment of moderate to severe pain. The mixed opioid-action/blocking-action appears to make buprenorphine safe as regards overdose and possibly less likely to be diverted than pure opioids. It may also provide an easier withdrawal phase, and due to a longer action, may allow for alternate-day dosing.

Court diversion
A programme of treatment, re-education or community service for individuals referred from criminal courts after being charged with drug-related criminal offences. Individuals are assigned to diversion programmes in lieu of prosecution, which is usually held in abeyance pending successful completion of the diversion programme. Pre-charge diversion refers to the systematic referral of those detected by the police to an alternative programme without prosecution (also see *alternatives to imprisonment* and *drug treatment court*).

1396 For more detailed discussion, see Legislating for Health and Human Rights: Model Law on Drug Use and HIV/AIDS, Module 1: Criminal law issues (Canadian HIV/AIDS Legal Network, 2006), online at www.aidslaw.ca/modellaw.

Decriminalisation and depenalization
Decriminalisation is the removal of an offence from the criminal law; the offence may still attract administrative penalties, although this need not be the case. Depenalization, a broader term, is the removal of penalties, criminal or administrative, for certain offences. The offence may remain prohibited, but no sanctions are applied.

Demand reduction
International drug control conventions use this term in relation to the aim of reducing consumer demand for controlled substances. Demand reduction strategies complement supply reduction and harm reduction approaches. Demand reduction is a broad term used for a range of policies and programmes which seek a reduction of desire and of preparedness to obtain and use illegal drugs. Demand for drugs may be reduced through prevention and education programmes to dissuade users or potential users from experimenting with illegal drugs and/or continuing to use them; drug substitution programmes (e.g. methadone); treatment programmes mainly aimed at facilitating abstinence, reduction in frequency or amount of use; court diversion programmes offering education or treatment as alternatives to imprisonment; broad social policies to mitigate factors contributing to drug use such as unemployment, homelessness and truancy. The success of demand reduction is conventionally measured by a reduction in the prevalence of drug use (i.e., by more abstinence).

Dependence syndrome
According to the WHO, "dependence, or dependence syndrome" is a need for repeated doses of the drug to feel good or to avoid feeling bad, or dependence is defined as "a cluster of cognitive, behavioural and physiologic symptoms that indicate a person has impaired control of psychoactive substance use and continues use of the substance despite adverse consequences".

Detoxification
The process by which a person who is dependent on a psychoactive substance ceases use, in such a way that minimises the symptoms of withdrawal and risk of harm. While the term "detoxification" literally implies a removal of toxic effects from an episode of drug use, in fact it has come to be used to refer to the management of rebound symptoms of neuroadaptation, that is, withdrawal and any associated physical and mental health problems.

"Diseases that pose a risk to others" / "socially significant diseases"
Terms that exist in the legislation of some countries of the Commonwealth of Independent States (CIS), usually included in laws on public health, and give rise to certain legal consequences. Lists of such diseases are generally approved by Ministries of Health. Lists of "diseases that pose a risk to others" generally include infectious diseases such as HIV infection, tuberculosis and others. Lists of "socially significant diseases" may include HIV infection and AIDS and drug and alcohol dependence. Inclusion in the list generally means that people with these conditions receive free medication and sometimes reimbursement of travel expenses to treatment facilities. It also means that people may face certain restrictions on their rights and be subject to additional legal obligations, such as being legally compelled to undergo treatment or disclose certain information.

Drug
According to the *WHO Lexicon of Alcohol and Drug Terms,* a drug is a substance that is, or could be, listed in a pharmacopoeia. The term often refers specifically to psychoactive drugs, and often, even more specifically, to illicit drugs, of which there is non-medical use in addition to any medical use. See *Narcotic drug*

Drug policy
The aggregate of policies designed to affect the supply and demand for illicit drugs and reduction of harms from their use. Drug policy covers a range of strategies on such issues as education, treatment, drug laws, policing and border surveillance. A balanced drug policy should include demand reduction, supply reduction and harm reduction.

Drug treatment court
Imposes court-supervised treatment for people dependent on drugs who have been charged with certain

offences, such as possession of or trafficking in small quantities, usually in lieu of the normal procedure of criminal prosecution. The circumstances under which a person is eligible for participation in a drug treatment court will vary depending on how a drug treatment court system is set up and defined in the law. Whether a person charged with an offence is eligible for diversion into a drug treatment court scheme before entering a plea to the offence with which he or she is charged, or must first plead guilty to the offence, will vary across jurisdictions. Normally, an accused person participates in a structured outpatient programme with case management, including by the court through regular supervision. Normally, if the person "succeeds" in the treatment programme, in the court's assessment, then the standard criminal penalty is not applied; if the person is deemed to "fail" with the requirements of the treatment programme imposed by the court, she or he may be prosecuted and punished through the normal criminal justice procedure. Drug treatment courts exist in Australia, Canada, the United States, the United Kingdom and some other countries. Though the drug treatment courts attempt to reduce harm to the accused of non-violent drug-related offences by diverting them from the penal system and assisting in rehabilitation, the fact that participants enter treatment under the threat of incarceration, or abstain from drugs to avoid sanctions, has serious implications for the human and legal rights of the offender. These include possible violations of the right to due process and the principle of presumption of innocence, considerations that should be addressed in the design of any such initiatives.[1397] Concerns have also been raised about whether the evaluations of drug treatment courts show them to be particularly effective, and whether resources are better spent on expanding access to voluntary drug dependence treatment services that are evidence-based, services for which the need often greatly exceeds the availability.

Gender and sex
The term "sex" refers to biologically determined differences, whereas the term 'gender" refers to differences in social roles and relations between men and women. Gender roles are learned through socialisation and vary widely within and between cultures. Gender roles are also affected by age, class, race, ethnicity and religion, as well as by geographical, economic and political environments.

Global Fund to Fight AIDS, Tuberculosis and Malaria
The Global Fund to Fight AIDS, Tuberculosis and Malaria, established in 2001, is an independent public-private partnership. Its purpose is to attract, manage and disburse additional resources to make a sustainable and significant contribution to mitigate the impact caused by HIV infection, tuberculosis and malaria in countries in need, while contributing to poverty reduction as part of the Millennium Development Goals.

Greater involvement of people living with HIV/AIDS (GIPA) and people who use drugs
GIPA, an acronym for the "greater involvement of people living with HIV/AIDS," appeared first in the 1994 final Declaration of the Paris AIDS Summit. Greater meaningful involvement of people living with HIV, people who use drugs, and people who are most at risk of HIV (and hepatitis C virus) in the national and international response to HIV and hepatitis C is essential for respecting and protecting human rights, and for the protection of individual and public health. Greater and meaningful involvement of affected communities in drafting, implementation, monitoring and evaluation of national HIV strategies, legislation and programmes — and of related laws, strategies and programmes, such as those dealing with drugs and drug use — is required as a matter of human rights such as the right to participate in decision making affecting one's life, and positively affects quality and efficacy of services.[1398]

Harm reduction
In the context of alcohol or other drugs, harm reduction refers to policies or programmes that focus directly on reducing the harm resulting from the use of alcohol or other drugs, both to the individual and the larger community. The term is used in particular for policies or programmes that aim to reduce the harm from drug use without necessarily requiring abstinence. Some harm reduction strategies designed to achieve safer drug use may, however, precede and support subsequent efforts to achieve total abstinence. Examples of harm reduction include needle/syringe exchanges to reduce rates of needle-sharing among injecting drug users, opioid substitution treatment and safer drug consumption facilities.
The term 'harm reduction' began to be used more widely in connection with attempts to stop the spread of HIV among injecting drug users in the early 1980s. The extent to which continued drug use is discouraged during the implementation of a harm reduction strategy varies greatly according to the guiding philosophy of the service provider. Harm reduction typically involves establishing a hierarchy of risky behaviours and involves individuals or communities working to find a position on the hierarchy which is acceptable to them while reducing harms or risk of harms. Broad definitions of harm reduction allow that abstinence-oriented programmes may be considered harm-reducing if they can be shown to reduce drug-related harm rather than just reduce use and if they are not coercive or punitive in their approach. Harm reduction as such is neutral regarding the wisdom or morality of continued drug use and should not be seen as synonymous with moves to legalize, decriminalize or promote drug use.

Highly active antiretroviral therapy (HAART)
Treatment aimed at aggressively suppressing viral replication in persons living with HIV and thereby slow the progress of HIV disease, as well as reducing infectiousness by dramatically reducing the person's viral load (i.e., level of virus in the person's blood or other bodily fluids). The usual HAART regimen combines three or more different antiretroviral medications (ARVs).

HIV-related disease
Symptoms of HIV-infection may occur both at the beginning of HIV infection and after a person's immune system is compromised by HIV, leading to AIDS. During the initial infection with HIV, when the virus comes into contact with the mucosal surface, it finds susceptible target cells and moves to lymphoid tissue where massive production of the virus ensues. This leads to a burst of high-level viraemia (virus in the blood stream) with wide dissemination of the virus. Some people may have flu-like symptoms at this stage but these are generally referred to as symptoms of primary infection rather that HIV-related disease. The resulting immune response to suppress the virus is only partially successful and some virus escapes and may remain undetectable for month to years. Eventually high viral turnover leads to destruction of the immune system, sometimes referred to as advanced HIV infection. HIV disease is, therefore, characterised by a gradual deterioration of immune function. During the course of infection, crucial immune cells, called CD4+ T cells, are disabled and killed, and their numbers progressively decline.

Human immunodeficiency virus (HIV)
The virus that weakens the immune system, ultimately leading to AIDS. There are HIV-1 and HIV-2 types of viruses, which are similar in their viral structure, modes of transmission, and resulting opportunistic infections, but have different geographical patterns of infection, and propensity to progress to illness and death. Compared to HIV-1, HIV-2 is found primarily in West Africa and has a slower, less severe clinical course. HIV is transmitted through body fluids, including blood (i.e. through blood transfusion, shared drug-injection equipment, shared implements for tattooing, or improperly sterilized medical equipment), via sexual activity that involves exposure to significant enough quantities of body fluids (e.g., genital secretions), and from mother to child *in utero*, during childbirth or by breast-feeding.

Human rights-based approach
An approach to making and implementing law and policy (at various levels) that is normatively based on international human rights standards and is directed to protecting and promoting human rights. In the context of HIV infection, a human rights-based approach is one that recognizes that human rights principles must guide HIV prevention and treatment efforts, including by informing relevant areas of law and policy, such as those dealing with drugs or regulating prisons and other places of detention. A human rights-based approach recognizes that access to goods, services and information for HIV prevention, care, treatment and support is a matter of human rights, and that the denial or violation of human rights increases the vulnerability of individuals and communities to HIV and undermines effective responses to the epidemic. Such an approach recognizes that respecting, protecting and fulfiling human rights, and in particular the rights of those who are most marginalized and vulnerable to infringements of human rights, is a key necessary element of effective policies and programmes. A human rights-based approach is relevant to international and national governmental organisations and structures, and to civil society organizations, engaged in responding to the HIV epidemic.

1397 For some additional discussion, see Legislating for Health and Human Rights: Model Law on Drug Use and HIV/AIDS, Module 1: Criminal law issues (Canadian HIV/AIDS Legal Network, 2006), online: www.aidslaw.ca/modellaw.

1398 For more detailed discussion, see: UNAIDS, Policy Brief: Greater Involvement of People Living with HIV (GIPA) (March 2007) and other documents at http://www.unaids.org/en/PolicyAndPractice/GIPA/default.asp; and "Nothing About Us Without Us" – Greater, meaningful involvement of people who use illegal drugs: a public health, ethical and human rights imperative (International edition), (Canadian HIV/AIDS Legal Network, International AIDS Alliance, Open Society Institute, 2008), online via www.aidslaw.ca/publications.

Incidence
HIV incidence (sometimes referred to as cumulative incidence) is the number of new cases arising in a given period in a specified population. UNAIDS normally refers to the number of people (of all ages) or children (0–14 years) who have become infected during the past year. In contrast, HIV prevalence refers to the number of infections at a particular point in time (like a camera snapshot). In specific observational studies and prevention trials, the term incidence rate is used to describe incidence per a hundred thousand persons per years of observation.

Injecting equipment
The paraphernalia used for drug injection. This can include such items as a needle and syringe, a spoon for mixing, water or acid for dissolving powdered drugs, filter material to draw the solution through when filling the syringe (e.g. piece of cigarette filter, cotton wool, paper), an alcohol swab to clean the injection site, and a tourniquet.

Key populations at higher risk of HIV exposure
UNAIDS recommends not to use the term "high-risk group" because it implies that the risk is contained within the group whereas, in fact, all social groups are interrelated. It may also lull people who don't identify with such groups into a false sense of security, and increase stigmatization and discrimination. Instead it recommends referring directly to "higher risk of HIV exposure", "sex without a condom", "unprotected sex", or "using non-sterile injection equipment" rather than to generalize by saying "high risk group."

Low-threshold and high-threshold services
Services adopting a low-threshold approach aim to reach more people in need of services (i.e. people who use drugs) earlier and to remain in contact with them in order to prevent health damage while not imposing many requirements that may pose barriers to their use of such services (e.g., abstinence from all drug use, compliance with strict rules that will make a service less user-friendly). Low-threshold services represent a unique opportunity for the provision of specific health services, such as education about how to minimize risks of harm associated with drug use, vaccination campaigns, and increasingly also the treatment of infectious diseases. High-threshold services impose more requirements on clients.

Methadone
A synthetic opioid drug used in maintenance therapy for those dependent on opioids, such as heroin. It has a long half-life, and can be given orally once daily with supervision. It is the most widely used treatment for opioid dependence in many countries. When given in an adequate dose to opioid-dependent individuals, methadone tends to reduce desire to use heroin and other opioids, eliminates opioid withdrawal, and can block the euphoric effects of other opioid drugs. Methadone is also used as a medication for pain management.

Men who have sex with men (MSM)
This term is useful as it includes not only men who self identify as gay or homosexual and have sex only with other men but also encompasses bisexual men, and men who identify themselves as heterosexual but who may nonetheless at times have sex with other men.

MTCT
Acronym for "mother-to-child transmission" of HIV. PMTCT is the acronym used to denote programmes aimed at the "prevention of mother-to-child transmission."

Naloxone
Naloxone is a narcotic antagonist which reverses the respiratory, sedative and hypotensive effects of heroin overdose. It can be injected intramuscularly, intravenously or subcutaneously. A nasal spray preparation is now also available in some countries. It is an opioid receptor blocker that antagonises the actions of opioids. It reverses the features of opiate intoxication and is prescribed for the treatment of overdose with that group of drugs.

Naltrexone
A drug that antagonises the effects of opioids. Its effects are similar to those of naloxone, but it is more potent and has longer duration of action (making naloxone more suitable for emergency use to rapidly reverse opioid overdose). It is used in various ways in the treatment of opioid dependence and also alcohol dependence. The most widely adopted dependence use is to prescribe at a dose that will block the psychoactive effects of all opioids; s the objective of such dosing is to minimise the chance of relapse to opioid use.

Narcotic drug
One kind of controlled psychoactive substance (see *Psychoactive substance*), of natural or synthetic origin, whose production and distribution are regulated by relevant UN Conventions and national legislation. In this report and in legal usage it is often used to mean illicit drugs and psychotropic substances, irrespective of their pharmacology.

Needle and syringe programme (NSP), needle exchange programme (NEP)
Interventions aimed at reducing the repeated use and sharing of needles, in order to reduce the transmission of blood-borne viruses (such as HIV and hepatitis) and other harms. Such programmes were first developed in response to the advent of HIV infection and quickly spread to many countries in which injecting drug use was experienced as a problem. Strictly speaking, a needle "exchange" programme provides clean injecting equipment in exchange for returned used needles which can then be disposed of safely. In practice, research has shown that restricting such programmes to pure "exchanges", and particularly a rule of one-to-one exchange that provides only one clean needle for every used needle returned, undermines the full public health benefit of such programmes by unnecessarily limiting access to sterile injecting equipment. As a result, many NSPs do not require a strict "exchange", but rather distribute clean needles on demand without such strict limitations, in the interests of maximizing users' access to sterile injection equipment. Many programmes will provide not only syringes but also related items needed to minimize the risks of blood-borne diseases and other injuries associated with drug use (e.g. cookers, alcohol swabs and other items), as well as also providing condoms and information about HIV and available services. Syringe dispensing machines and pharmacy-based distribution (and easy and cheap syringes available for purchase at the pharmacy) are other means of ensuring access to sterile injecting equipment.

Opiate
According to the *WHO Lexicon of Alcohol and Drug Terms*, "opiate" is one of a group of alkaloids derived from the opium poppy with the ability to induce analgesia, euphoria, and in higher doses, stupor, coma and respiratory depression. The term opiate excludes synthetic opioids (e.g. methadone).

Opioid
According to the *WHO Lexicon of Alcohol and Drug Terms*, opioid is the generic term applied to alkaloids from the opium poppy, their synthetic analogues, and compounds synthesized in the body, which interact with the same specific receptors in the brain, have the capacity to relieve pain, and produce a sense of well-being (euphoria). The opium alkaloids and their synthetic analogues also cause stupor, coma and respiratory depression in high doses. Over time, opioids induce tolerance and neuroadaptive changes that are responsible for rebound hyperexcitability when the drug is withdrawn.

Opioid substitution therapy (or treatment) (OST)
A method of pharmacological treatment for those with opioid dependence, proven to be effective and widely used in many countries for decades. In addition to its own therapeutic value as a method of treating those with addictions to illicit opioids (e.g., heroin), OST is recommended by UN and international and national health authorities as an effective and important intervention to prevent transmission of HIV and other blood-borne infections among people who inject drugs. OST is defined as the administration of thoroughly evaluated opioid agonist, by accredited professionals, in the framework of recognized medical practice, to people with opiod dependence, for achieving defined treatment aims[1399]. In other words, the person with opioid dependence is administered a certain medicine (opioid agonist) obtained legally under prescription from qualified medical personnel and consumed in less risky ways (e.g., as an oral solution in the case of methadone or sublingual tablets of buprenorphine), in place of illegally-obtained opioids that are often consumed in ways that risk disease transmission (e.g. injecting with non-sterile equipment). Agonist pharmacotherapy programmes may be of two general types: in detoxification

1399 Guidelines for the Psychosocially Assisted Pharmacological Treatment of Opioid Dependence, WHO, 2009

programmes, doses of the agonist will be reduced over a period of time until a drug-free state has been reached, while maintenance programmes prescribe higher doses of the substitute agonist for longer periods of time.[1400]

Opportunistic infections
Illnesses caused by various organisms, some of which usually do not cause disease in persons with healthy immune systems. Persons living with advanced HIV infection may have opportunistic infections of the lungs, brain, eyes and other organs. Opportunistic illnesses common in persons diagnosed with AIDS include pneumonia, cryptosporidiosis, bacterial infections, other parasitic, viral and fungal infections; and some types of cancers. Tuberculosis is the leading HIV-associated opportunistic infection in developing countries.

Outreach
A community-based activity with the overall aim of facilitating improvement in health and reduction of drug-related risk or harm for individuals and groups not effectively reached by existing services or through traditional health education channels. Peer outreach projects use current and former members of the target groups (such as injecting drug users) as volunteers and paid staff.

Overdose
According to the *WHO Lexicon of Alcohol and Drug Terms*, "overdose" is the use of any drug in such an amount that acute adverse physical or mental effects are produced. Overdose may produce transient or lasting effects, or death; the lethal dose of a particular drug varies with the individual and with circumstances (including the concentration of the drug consumed).

Peer intervention
A treatment or service that is delivered by a trained individual who is close in gender or age group or other socio-economic category to the target group (e.g. personal experience of drug use).

People living with HIV
UNAIDS recommends avoiding expressions "people living with HIV and AIDS" and the abbreviation PLWHA, and to use instead "people living with HIV" and PLHIV. This reflects the fact that an infected person may continue to live well and productively for many years. A term such as "people living with HIV" is also much preferable to terms such as "AIDS patients" or "AIDS carriers" or "AIDS victims," because it defines people by their disease first and foremost, rather than emphasizing that they are people first and foremost, and entitled to respect and protection of their rights as persons, something particularly important in the face of widespread HIV-related stigma and discrimination, including sometimes in the law. Groups of PLWH have rejected labels such as "AIDS victims" because "it implies helplessness, and dependence upon the care of others."[1401] With the term "person living with HIV/AIDS," a "new social and/or political identity was born, stressing that people who are HIV positive or have AIDS are not dying; they are living and they are able to take care of their own lives." It should also be noted that referring to some people living with HIV as "innocent victims" wrongly implies that people infected in other ways are somehow deserving of punishment, further contributing to the stigmatization and discrimination surrounding HIV and affecting particular vulnerable groups.

People who use drugs and people who are dependent on drugs (or with drug dependence)
For some people, these terms are preferable to terms such as "drug addicts" or "drug (ab)users," which are seen as derogatory and which often result in alienation rather than creating the trust and respect required when dealing with those who use drugs. Similarly to using a term such as "people living with HIV", terminology such as "people who use drugs" avoids reducing people to the fact that they use or inject drugs, and instead identifies them as people first and foremost, clarifying that drug use or injection drug use is just one aspect of their lives. Given the widespread dehumanization of people who use drugs, and in particular people with drug dependence, insisting on the humanity and dignity of people who use drugs is an important reminder, including to those who makes laws and policies that affect very profoundly the lives of people who use drugs.

1400 WHO, Evidence for Action Technical Papers: Effectiveness of drug dependence treatment in preventing HIV among injecting drug users (2005), online: http://www.who.int/hiv/pub/idu/e4a-drug/en/index.html.

1401 C Cornu, K Attawell. The Involvement of People Living with HIV/AIDS in Community-based Prevention, Care and Support Programs in Developing Countries. A Multi-country Diagnostic Study. Washington, DC, and London, UK: The Populations Council Inc and the International HIV/AIDS Alliance, 2003, at p. 22, with reference to the "Denver Principles." Available via www.aidsalliance.org/sw7442.asp.

Prevalence
Usually given as a percentage, HIV prevalence quantifies the proportion of individuals in a population who have HIV at a specific point in time. UNAIDS normally reports HIV prevalence among adults, aged 15–49 years. We do not write "prevalence rates" because a time period of observation is not involved. HIV prevalence can also refer to the number of people living with HIV as in "by December 2007, an estimated 33.2 million people were living with HIV worldwide."

Prevention
An intervention designed to avoid or substantially reduce risk for the acquisition or further development of adverse health and interpersonal problems. Programmes at preventing harmful drug use vary widely in content and philosophy. The most effective programmes are multidimensional and contain a mixture of straight-talking education sessions about drugs and drug use; skills to deal with stress and personal and relationship problems; and drug resistance skills. The specific content of a programme can be specifically adapted to the nature and needs of the target population. HIV prevention includes harm reduction measures such as needle and syringe programmes (NSPs), opioid substitution therapy (OST), supervised drug consumption sites, condom distribution, as well as distribution of information about HIV and easy access to health services.

Prisons
For purposes of simplicity, this report uses the term "prisons" broadly to denote all institutions of the correctional system, including places of pre-trial and post-conviction detention. The term "prisoner" is used broadly to include adults detained at correctional facilities during criminal investigations, prior to or after sentencing.

Psychoactive substance
According to the *WHO Lexicon of Alcohol and Drug Terms*, a "psychoactive substance" is one that, when ingested, alters mental process, that is, thinking or emotion This term is the most neutral and descriptive term for the whole class of substances, licit and illicit.

Registry of people who use drugs and people dependent on drugs
In many countries of the Commonwealth of Independent States (CIS), drug dependence treatment services keep registries of people who are characterized as using drugs (and those who are dependent on drugs). Commonly, the practice is to maintain a "preventive" registry, which holds data on people who use drugs, and keeps it usually for a set term such as one year, while another registry holds data on people diagnosed as being drug-dependent and keeps that data for a longer period, usually not less than 3-5 years. Being on the registry generally carries a range of legal consequences, including limitations of certain rights. Often employers and educational institutions request that a prospective employee or student provide a certificate confirming that he or she is not listed in the drug registry. There are also reports of frequent violations of confidentiality of information on these registries, and in many instances, the law expressly provides for easy access to such information by law enforcement authorities or for various law enforcement purposes, which raises human rights concerns discussed in this report.

Rehabilitation
According to the *WHO Lexicon of Alcohol and Drug Terms*, in the field of substance use, "rehabilitation" is the process by which an individual with a drug-related problem achieves an optimal state of health, psychological functioning and social well-being. Rehabilitation typically follows an initial phase of treatment in which detoxification and, if required, other medical and psychiatric treatment occurs. It encompasses a variety of approaches including group therapy, specific behavioural therapies to prevent relapse, involvement with a mutual-help group, residence in a therapeutic community, vocational training and work experience. There is an expectation of social integration into a wider community.

Relapse
According to the *WHO Lexicon of Alcohol and Drug Terms,* relapse is a return to drinking or other drug use after a period of abstinence, often accompanied by reinstatement of dependence symptoms. Some distinguish between relapse and lapse ('slip'), with the latter denoting an isolated occasion of alcohol or drug use. The rapidity with which signs of dependence return is thought to be a key indicator of the degree of drug dependence.

Relapse prevention
According to the *WHO Lexicon of Alcohol and Drug Terms,* relapse prevention is a set of therapeutic procedures employed in cases of alcohol or other drug problems to help individuals avoid or cope with lapses or relapses to uncontrolled substance use. The procedures may be used with treatment based on either moderation or abstinence, and in conjunction with other therapeutic approaches. Patients are taught coping strategies that can be used to avoid situations considered dangerous precipitants of relapse, and shown, through mental rehearsal and other techniques, how to minimize substance use once a relapse has occurred.

Remission
A disease is said to be in remission if symptoms cease for a while, even if the underlying condition has not been cured. In relation to drug dependence, people who are dependent on drugs are said to be in remission if they have achieved a period of abstinence.

Right to health
The "right to health" is recognised in various international documents, including the 1948 *Universal Declaration of Human Rights*. The 1966 *International Covenant on Economic, Social and Cultural Rights*, one of the primary human rights treaties of the UN system that has been ratified by a large majority of the world's states, recognizes the "right to the enjoyment of the highest attainable standard of physical and mental health." Every state has ratified at least one international human rights treaty recognising the right to health in some form, such as the *Constitution of the World Health Organization* (adopted in 1946 and entered into force in 1948) or various regional human rights treaties. The right to health includes "underlying determinants of health", such as safe drinking water and food, adequate nutrition and housing, access to essential medicines, healthy working and environmental conditions, health-related education and information, and gender equality. Access to medication for the treatment of HIV infection and tuberculosis has specifically been recognized repeatedly by UN members states as a fundamental element of the right to health. The right to health requires non-discriminatory access to health goods, services and information. The right to health includes the right to be free from non-consensual medical treatment, and to be free from torture and other cruel, inhuman or degrading treatment or punishment.[1402]

Risk of harm to self or others
A basis on which a person may justifiably be subjected to involuntary treatment (e.g. for drug dependence). Whether a person poses an imminent and significant risk of causing harm to himself or herself, or to others, should be determined on an individual basis by an appropriate independent legal authority, with the benefit of expert, evidence-based clinical assessment as to the risk of harm, the severity of the harm and whether imposing treatment that is available holds a reasonable prospect of assisting the person to address his or her drug dependence so as to avoid that harm.

Supervised (or safer) injection sites / supervised drug consumption facilities
A health facility that is legally approved and that allows the consumption of drugs with sterile equipment under the supervision of health professionals and with access to medical care if needed, including the potential for intervening in the event of an overdose. It is a specialised health intervention, a part of a wider network of services for people who use drugs. Among other objectives, such facilities aim to reduce the risk of transmission of blood-borne infections, in particular HIV and hepatitis, and to reduce the likelihood of illness and death resulting from overdose. Ideally, such facilities will also provide basic health care for simple medical problems commonly experienced by people who use drugs (e.g. abscesses in injecting spots) and provide a means of connecting people to other health or social services (e.g. treatment for drug dependence, assistance with getting food or shelter).

1402 For more detail about the right to health in international law, see Office of the UN High Commissioner for Human Rights and the WHO, The Right to Health: Fact Sheet No. 31 (June 2008), online: http://www.ohchr.org/Documents/Publications/Factsheet31.pdf.

Sexually transmitted infection (STI)
Also called venereal disease (VD), infections spread by the transfer of organisms from person to person during sexual contact. In addition to 'traditional' STI (e.g., syphilis, chlamydia, gonorrhoea), the spectrum of STIs includes HIV, which causes AIDS, human papilloma virus (HPV) which can cause cervical or anal cancer, genital herpes, hepatitis B and other infections. The complexity and scope of sexually transmitted infections have increased dramatically since the 1980s; more than 20 disease-causing organisms and syndromes are now recognized as belonging in this category.

Sex work/Prostitution
According to UNAIDS recommendations, the term "prostitution" should be used only in respect of juvenile prostitution. For adults, the term "sex work" should be used. The term "sex worker" is intended to be non-judgemental, focusing on the conditions under which sexual services are sold.

Stigma and discrimination[1403]
As the traditional meaning of stigma is a mark or sign of disgrace or discredit, the correct term would be stigmatization and discrimination. HIV-related stigmatization and discrimination is a "process of devaluation" of people either living with or associated with HIV infection . The stigma often stems from the underlying stigmatisation of sex and injecting drug use. Discrimination follows stigma and is the unfair and unjust treatment of an individual based on his or her real or perceived HIV status. Stigma and discrimination breach fundamental human rights and can occur at a number of different levels including political, economic, social, psychological and institutional. Stigma and the potential for discrimination are strong incentives for people to avoid being tested for HIV. This can lead to the risk of faster disease progression for the individual living with HIV and also contributes to the risk of spreading HIV to others. HIV-related stigma builds upon, and reinforces, existing prejudices. It also plays into, and strengthens, existing social inequalities – especially those of gender, sexuality and race (e.g., stigmatization and discrimination against men who have sex with men or sex workers).

Substitution treatment (substitution therapy, drug substitution, medication assisted therapy)
Treatment of drug dependence by prescription of a substitute drug for which cross-dependence and cross-tolerance exist. The term is sometimes used in reference to a less hazardous form of the same drug used in the treatment. The goals of drug substitution are to eliminate or reduce use of a particular substance, especially if it is illegal, or to reduce harm from a particular method of drug use (e.g., sharing of needles) such as the attendant dangers to health and the social consequences. Drug substitution is often accompanied by psychological and other treatment. Opioid substitution therapy (OST) is the most common form of drug substitution and is conducted using such evidence-based and approved medications as methadone and buprenorphine.

Supply reduction
A broad term used for a range of activities designed to stop the production and distribution of illicit drugs. Efforts at reducing production often include crop eradication or through large programmes of developing alternative income-generating activities for those growing crops used to produce illicit drugs, as well as the suppression of illicit laboratories and the control of precursor chemicals, while policing efforts aim to disrupt the local or cross-border distribution and sale of substances. In some cases, supply reduction efforts have involved large-scale military operations. Supply control is a term often used to cover police and customs activities.

Testing
HIV testing is pivotal to both HIV prevention and treatment interventions. It is widely recognised that all HIV testing should reflect the "three C's" — that is, testing should be *confidential*; accompanied by *counselling*; only be conducted with informed *consent* which is voluntarily given. **VCT** is an abbreviation for the process of "voluntary counselling and testing," and is also known as **"client-initiated testing**," in opposition to what has been labelled as "provider-initiated testing". **Provider-initiated testing** refers to the process of a health care provider performing HIV testing under certain defined circumstances when an individual is seeking medical care, such as when a patient presents with symptoms that may be attrib-

1403 This definition is based on the UNAIDS fact sheet "Stigma and Discrimination" (December 2003).

utable to HIV infection or has an illness associated with HIV such as tuberculosis, or as part of the clinical evaluation of certain patients, such as those who present with an STI or women who are pregnant. Under the **opt-in approach**, testing is done only once the patient has formally given consent for HIV testing. Under the **opt-out approach**, testing is done routinely unless the patient declines to be tested. There are ongoing debates about whether "opt-out" approaches to HIV testing are advisable or justified, but there is consensus that all HIV testing should always be carried out under conditions respecting three Cs – confidentiality, counselling and informed consent.

Anonymous vs. confidential testing and treatment: Testing/treatment is considered to be truly *anonymous* when no identifying information (such as name, address and other information) of the person is taken, known or requested by a service provider. Testing/treatment is considered to be *confidential* when information about the person is kept secret and known only to certain parties, such as the health care provider working with a patient. As a matter of ethics, human rights and good health practice, testing and treatment should always be at least confidential, meaning that a patient's information cannot be shared without his or her consent, and only very limited exceptions may be allowed by law with proper and careful justification. Experience with HIV infection and STIs, and the stigmatization and discrimination related to them, has also shown the value of ensuring access to truly anonymous testing for such infections so as to increase the number of people willing to seek testing, particularly those who may be most marginalized and also at greater risk of infection.

Mandatory vs. compulsory vs. voluntary testing: According to UNAIDS, HIV testing (and treatment) should be voluntary. But sometimes laws and policies, or even the practices of some actors (both public and private), derogate from these principles and impose *mandatory* or *compulsory* testing or treatment. HIV testing can be said to be *mandatory* when it is made a necessary prerequisite for a person to obtain a specific status, benefit, service or access to a given situation, or is a necessary consequence of this, but the individual still has the "choice" of avoiding testing by forgoing such a status, benefit, service or access. (The degree to which this is truly a free "choice" will obviously vary in the circumstances and for the individual.) For example, imposing a requirement of HIV testing as a condition of donating blood, immigrating to a country or employment, is to impose mandatory testing. The person can avoid being tested for HIV by forgoing employment, immigration, or being a blood donor. HIV testing (or other testing, such as for drug use) can be said to be *compulsory* when it is required by a law or policy and the person cannot choose to refuse testing and cannot avoid it except upon pain of legal penalty — for example, if a court or a law enforcement body orders a person to be tested for HIV (or for drug use) and force can be used to compel that person to undergo testing if he or she objects. According to UNAIDS, mandatory HIV testing is permitted only in case of blood and bodily tissues or other substances donated for purposes of possible transplantation; other instances of mandatory HIV testing (e.g. as a condition of employment or access to services) are not justified. Compulsory testing will rarely, if ever, be justifiable. However, some countries employ involuntary testing and treatment in wider circumstances (e.g. compulsory HIV and drug testing of prisoners, compulsory drug dependence treatment of prisoners), which unjustifiably violate human rights.

Drug dependence treatment

According to WHO, the term "treatment" refers to "the process that begins when psychoactive substance abusers come into contact with a health provider or any other community service and may continue through a succession of specific interventions until the highest attainable level of health and well-being is reached." More specifically, treatment may be defined "as a comprehensive approach to the identification, assistance, health care, and social reintegration with regard to persons presenting problems caused by the use of any psychoactive substance…. The definition of treatment uses the broad concept of rehabilitation adopted by United Nations agencies such as the International Labour Organisation (ILO), the United Nations Educational, Scientific and Cultural Organization (UNESCO) and WHO. It includes the equalization of opportunities and community involvement. The definition is also compatible with the WHO's constitutional objective, which is 'the attainment by all peoples of the highest possible level of health.' The aim of treatment, within this broader context, is to improve the health and quality of life of persons with problems caused by their use of psychoactive substances."[1404] Treatment services and opportunities can include detoxification, the use of substitution therapy (including for maintenance on such therapy over a longer-term) and/or psychosocial therapies and counselling. Treatment aims at reducing the dependence on psychoactive substances, as well as reducing the negative health and social consequences caused by or associated with the use of such substances.

Compulsory or coerced treatment

As noted above, a general underlying principle of health care interventions is that such interventions should be only undertaken with informed consent, meaning with the voluntary agreement of the patient. In some cases, drug dependence treatment (and treatment of other conditions) may be at odds with this principle of voluntariness. Treatment may be *compulsory* in the sense of being effectively imposed by force by some authority, with no possibility of avoiding the intervention, such as drug dependence treatment imposed upon some people in prison according to the law in some countries. Treatment may also be *coerced* under the law; for example, a court may order that an individual undergo some form of drug dependence treatment as an alternative to a custodial sentence. Treatment is coerced in the sense that failure to enter the programme or comply with its rules and regulations may result in the individual receiving the standard criminal justice penalty. Involuntary treatment raises human rights concerns; compulsory treatment will possibly be justifiable only in very exceptional circumstances and even systems for coercing to treatment (e.g., drug treatment courts) require careful scrutiny in light of the need to respect such rights as liberty, privacy and security of the person.

Withdrawal syndrome

A group of symptoms of variable severity which occur on cessation or reduction of drug use after a prolonged period of use and/or in high doses. The syndrome may be accompanied by signs of both psychological and physiological disturbance. A withdrawal syndrome is one of the indicators of a dependence syndrome.

Vilification

Vilification is any public act that could incite others to hate, have serious contempt for, or severely ridicule an individual because they belong to a particular group or have a particular characteristic (e.g., people with HIV, or people who use or are dependent on drugs).

1404 WHO Expert Committee on Drug Dependence, Thirtieth Report., WHO Technical Report Series No. 873 (Geneva, 1998), p. 3, online via http://www.who.int/substance_abuse/right_committee/en/index.html.