Canadian HIV/AIDS Legal Network

HIV/AIDS POLICY & LAW REVIEW

VOLUME 15, NUMBER 2, APRIL 2011

Legislative and policy analysis of HIV prevention, treatment and care for people who use drugs and incarcerated people in Central Asia and Azerbaijan

In January 2011, the Regional Office for Central Asia of the UN Office on Drugs and Crime (UNODC) and the Canadian HIV/AIDS Legal Network released an extensive report assessing the legislative and policy environment affecting the response to HIV in six countries of the Commonwealth of Independent States (CIS). The report, which draws in part upon the work of a national expert group in each country, puts forward dozens of recommendations for legislative and policy reform, including recommendations for specific reform tailored to the situation in each of the participating countries, with a particular focus on addressing the fast-growing HIV epidemic linked to injection drug use and in prisons.

The full text of the report — *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* — is available on-line in both English and Russian via either www.unodc.org/centralasia or

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Partial funding for this publication was provided by the Public Health Agency of Canada.

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www.aidslaw.ca/centralasia. This article summarizing key findings and recommendations was prepared by David Cozac and Richard Elliott.[1]

Introduction

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]

Although the six countries that form the basis of 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 them face concentrated HIV epidemics driven predominantly by unsafe drug-injecting practices with significant potential for the further rapid spread of HIV.[2] HIV in prisons is another specific area of major concern and, given the extensive criminalization of people who use drugs, is linked heavily to injection drug use both inside and outside prisons. In addition, tuberculosis (TB) is a serious public health problem in the region and a major contributor to deaths among people with immune systems compromised by HIV. TB prevalence is particularly high among people injecting drugs and people in prison.[3]

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 programs regularly reach only 10% of the estimated number of injecting drug users."[4] Interventions such as needle and syringe programs (NSPs) and opioid substitution therapy (OST) (e.g., medications such as methadone and buprenorphine) are widely recognized internationally as key elements of an effective response to HIV among people who inject drugs and in prisons. Yet overall access to such services remains exceedingly limited for these populations in the six participating countries, in part because of legal and social barriers.

The need for human-rights based legislative and policy reform

The assessment conducted by UNODC, the Legal Network and national experts showed that there are many common issues of concern in the legislation and policies of the project countries — and many ways in which reforms based on evidence and on human rights norms could significantly contribute to a more effective response to HIV.

As almost everywhere in the world, in the participating countries people who use illegal drugs and people in prisons are often among the most marginalized and stigmatized groups of society. Given administrative and criminal penalties for drug use and possession of even very 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).[5] Inside prisons, people are often at higher risk of HIV infection, because of sharing drug-injection and tattooing equipment, as well as unprotected sex, both consensual and

[1] All reasonable efforts were made by UNODC and the Canadian HIV/AIDS Legal Network to verify the accuracy of the information in the report (and summarized here) as of December 2009. Ongoing processes of legislative and policy reform, in part resulting from this project, mean some changes have since occurred; in some cases, those are noted here.

non-consensual. Conditions in prisons and pre-trial detention settings, including overcrowding, are poor and exacerbate damage to the health of individuals and to public health, such as contributing to high TB prevalence.

Outdated national laws often impede evidence-based approaches to HIV prevention among vulnerable groups such as people who use drugs and incarcerated people.

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. The result of these structural, legal and social barriers is that hundreds of thousands of people who use drugs and people in prison have limited or no access to prevention and health care services.

However, 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.

It is widely recognized that responses to HIV and AIDS are much more effective if human rights, particularly of those most vulnerable to HIV infection, are protected.

International human rights treaties oblige ratifying states to *respect*, *protect* and *fulfill* a range of human rights, including in and through their national laws and policies. This includes the obligation to take positive measures to realize, over time, the right to the highest attainable standard of health for all [6] — and this includes people who use drugs and incarcerated people. The project countries have also committed to respecting and protecting numerous civil and political rights that are 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, and to receive and impart information.[7] 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 hinders their access to health and other services.

Summary overview of the project countries

Drug use and related risk behaviour

According to the UN, Central Asia as a region has experienced a dramatic rise in drug use, including injection of opioids.[8] A history of drug use is common among people imprisoned in the project countries, as is injection drug use in prisons. Sharing needles is a common practice: many prisoners reported lending, renting or selling their used needles to others for injecting.[9] 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.[10]

HIV epidemic

Until 1994, there had been few registered cases of HIV infection in the countries of the region.[11] 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,[12] and there was a 1600% increase in HIV prevalence between 2002 and 2004.[13] All six of the participating countries are now experiencing HIV epidemics concentrated among people who inject drugs and their sexual partners, sex workers and to a lesser (but likely under-reported) degree, among men having sex with men.[14]

The single largest driver of the epidemic in the region is unsafe injecting practices widespread among people who use drugs.[15] 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.[16]

Health care systems and services

In each country, the Constitution guarantees free health care services to some extent, but there is a significant gap between proclaimed legal guarantees and the reality.[17] Some of the national expert groups participating in this project have reported that persons seeking medical care often have to pay for such things as medical supplies, meals, linen or prompt admission to hospital.

All six of the countries are experiencing HIV epidemics concentrated among people who inject drugs.

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 six countries have special AIDS centres responsible for HIV prevention and treatment, established in the early 1990s. While the approach seemed progressive at the time, doubts have since been raised about its efficacy — including that concern that singling out HIV from the broader system of public health care impedes the integration of HIV-related services with services for the prevention and treatment of TB, drug dependence and viral hepatitis.

Each 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." (The exception is Kyrgyzstan, which instead adopts annually a "Programme of State Guarantees" determining eligibility for certain free primary health care services). Both HIV infection and drug dependence are included in the scope of such coverage in all six countries, although in some circumstances certain treatment is only partially covered.

All six countries adopted specific statutes on HIV and AIDS in the mid-1990s, generally modelled on the Soviet Union's 1990 law. 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. 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.[18]

Although the countries have implemented voluntary HIV testing and counselling services, often these — and a clear requirement of informed consent to testing — are not formally reflected in or required by the law. In addition, with the exception of Kyrgyzstan, the participating countries' national laws on HIV and/or their subsidiary regulations contain very broad provisions on involuntary HIV testing for various categories of people.

Drug dependence treatment (narcological assistance)

In all six countries, treatment for drug dependence is provided in specialized "narcological" hospitals and in narcological offices in general hospitals. However, in accordance with the Soviet-era narcological system, treatment is generally based on detoxification with the limited use of rehabilitation and psychological methods. Other approaches have faced difficulty gaining acceptance even in the post-Soviet environment; this includes opioid substitution treatment using medications such as methadone and buprenorphine.[19]

At the time of publication of the UNODC/Legal Network report, despite solid evidence gathered over decades in other jurisdictions and endorsement by the UN's specialized technical agencies, opioid substitution therapy (OST) had been implemented only in three of six countries (Azerbaijan, Kyrgyzstan,

Kazakhstan), where the coverage of the services remains very limited. Kyrgyzstan was the first to implement opioid substitution treatment in 2002. In Tajikistan, government officials indicated that OST pilot projects were planned for the near future. In Uzbekistan, OST was available as of 2004, but in 2009 the government discontinued the projects. OST remains unavailable in Turkmenistan.

Harm reduction programs

Kyrgyzstan was the first country in the region to establish harm reduction programs when it launched needle exchange programs in Bishkek and Osh in 1999.[20] At this writing, needle and syringe programs exist in five of the six 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 programs for drug users. This often puts such programs as do exist in a precarious position, given the overwhelming emphasis on punitive and coercive approaches to drugs and those who use them (including as a result of drug dependence).

Correctional systems

Health care services in prisons are provided by health care departments within the relevant Ministry that has responsibility for the prison system, rather than being the responsibility of the Ministry of Health. According to the law in each country, prisoners with HIV are to receive antiretroviral treatment (ART). However, interviews conducted by the national expert groups demonstrated that health care services in prison are not equal to the services provided in the outside community

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.[21] In most of the project countries, 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, albeit not comprehensive programs. (Official reports from Turkmenistan claim that there are no cases of HIV infection in its prisons and no drug use.)

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) to introduce NSPs in prisons — programs 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.[22] In three 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.[23] (In February 2010, it was reported that Tajikistan would be piloting NSPs in prisons, and would start with educational sessions for staff and prisoners.[24])

Legislation in all of the countries also authorizes compulsory drug dependence treatment in prisons, but the implementation of such treatment varies. Meanwhile, voluntary treatment for drug dependence is not always accessible to patients in need. As of August 2008, pilot projects providing opioid substitution treatment (using methadone) were underway in prisons in Kyrgyzstan, but none of the other project countries had implemented access to OST in prisons.

Human rights situation: HIV, drug use and prisons

Drug laws and policies in all six countries are strict in punishing people who use drugs. A wealth of evidence has been amassed demonstrating that such policies contribute to the marginalization and stigmatization 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.[25] 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.[26] According to the same report, once apprehended, detainees are subject to extortion, threats and physical ill-treatment; many may succumb to pressure from law enforce-

ment 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 by police, and of torture of detainees. 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 are sex workers, forced sex and coerced confessions.[27] 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.[28] 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.[29]

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 toward 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 have targeted people who use needle exchange sites for surveillance and arrest.[30] 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.[31] 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 programs) because being identified as a drug user may result in further targeting by police.

Drug laws and policies in these countries are strict in punishing drug users.

The national expert groups from the six countries 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.[32]

Prison conditions remain harsh and life-threatening. Prisons are generally overcrowded and unsanitary, and disease, particularly TB, is a serious problem. For example, government officials in Tajikistan reported that 36 prisoners died of tuberculosis or AIDS-related diseases in 2007.[33] 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.[34] 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.[35] Corruption is widespread and prisoners must pay prison guards for privileges and sometimes even for health care.[36]

Administrative and criminal law issues

In each of the six countries, the law and its implementation reflect a predominantly 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. The countries vary in how they define various "small" or "large" (or even "extra large") quantities of drugs, and the administrative and criminal penalties associated with the possession of these different amounts. For example, at this writ-

ing, Uzbekistan and Kazakhstan have comparatively stricter definitions of quantities and harsher penalties, while Tajikistan takes a somewhat more liberal approach.[37] In all cases, however, the amounts for which possession triggers legal liability are quite small by any objective measure that considers realistic patterns of use by people with addictions — and in some cases, even minute amounts trigger serious legal consequences.

The countries' national laws generally make 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".[38] Drug use *per se* is formally prohibited in several of the project countries, although it is not always penalized (e.g., accompanied by a specific penalty under the country's administrative or criminal code).[39]

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.[40] 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.[41]

In addition, other areas of criminal and administrative law may hinder an effective response to HIV among other vulnerable groups in addition to people who use drugs or are in prison. For example, both Uzbekistan and Turkmenistan still criminalize consensual sex between men.[42] All of the project countries except Kyrgyzstan maintain provisions imposing both administrative and criminal liability on sex workers. All six countries have HIV-specific provisions in their *Criminal Codes* regarding exposure or transmission. These kinds of legal provisions run contrary to international human rights standards and/or international policy recommendations.

The national response to drugs accords a predominant role to law enforcement, rather than health agencies.

Legislation related to health care systems and services

In each of the 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 countries, people who use drugs have limited access to health care and HIV prevention. Harm reduction services are rare, marginalized and not integrated into legislation and governmental policies.

Compulsory drug dependence treatment in one form or another exists in all six countries, 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 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 *(лечебнотрудовой профилакторий)* run by the Ministry of Interior.

The level of compulsory treatment of drug dependence for non-offenders varies in the 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 the UNODC (UNODC, 2009, unpublished data). Compulsory drug dependence treatment for prisoners is used in all countries.[43]

In all of the countries, it is standard practice to *register* at narcological facilities the names and other information about people who use controlled substances and people with drug dependence. The 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 countries are out-dated, with unjustifiably broad 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 are not fully voluntary. There are also frequent breaches of confidentiality regarding HIV status of those tested.

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 programs 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 terms of 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);

Many of the national HIV policies in the six countries are out-dated, with unjustifiably broad provisions for mandatory HIV testing.

- 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.

As for HIV prevention and treatment, there is a need to develop 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.

Addressing HIV and drug dependence in prisons

As noted above, in all the 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 incar-

ceration for drug offences, including providing treatment and rehabilitation services as alternatives, instead of imposing these *in addition to* criminal penalties.[44] According to national laws, voluntary drug dependence treatment in prisons is provided in almost all countries (with the exception of Turkmenistan). However, national experts note that, in reality, very few people in prison who need drug dependence treatment undergo it voluntarily.

In all of the 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 order to strengthen the response to HIV in prisons, norms and regulations should be developed that will:

- include HIV prevention and treatment in prisons in national strategies and programs 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.

Legislative discrimination and other restrictions of rights of people living with HIV or vulnerable to HIV

All six of the 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 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.

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.

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 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 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).

In order to counter such discrimination embedded in the law, it is necessary to 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.

Conclusion

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 programs in a few others), and limited or no rehabilitation and overdose prevention programs 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.

National policy-makers and legislators should 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 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).

Reforms should also be reflected in national programs on HIV, tuberculosis, drug control and criminal justice/penal reform. To make them 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.

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

[3] *Towards Universal Access* (2008), pp. 36-38.

[4] Ibid, p. 63.

[5] 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).

[6] *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. E/C.12/2000/4 (2000).

[7] *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.

[8] UNDP, Central Asia Human Development Report — "Bringing down barriers: Regional cooperation for human development and human security," *Central Asia Human Development Report* (2005), p. 122 [hereinafter "*Central Asia Human Development Report 2005*"].

[9] *Central Asia: Kyrgyz Republic, Tajikistan and Uzbekistan — Regional Study on Drug Use and HIV/AIDS, Regional Summary* (UNODC and World Bank, 2007), p. 52.

[10] Ibid.

[11] 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. 11 [hereinafter "Reversing the Epidemic"].

[12] *Central Asia Human Development Report 2005*, p. 146.

[13] Ibid.

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

[15] *Central Asia Human Development Report 2005*, p. 123.

[16] Ibid.

[17] 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).

[18] 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.

[19] E.g., see A. Latypov et al, *Opioid Substitution Therapy in Central Asia: Towards Diverse and Effective Treatment Options for Drug Dependence* (Eurasian Harm Reduction Network, 2010).

[20] D. Wolfe, *Pointing the Way: Harm Reduction in Kyrgyz Republic* (Harm Reduction Association of Kyrgyzstan, 2005).

[21] 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.

[22] 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).

[23] Jürgens, *Interventions to address HIV in prisons, supra*, p. 19–20.

[24] UNDP Tajikistan, "Needle and syringe exchange programmes for penitentiary facilities have started in Tajikistan," *UNDP Bulletin: Saving Lives*, Issue #11 (February 2010).

[25] 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 Global "War on Drugs" (New York: Open Society Institute, 2009)*.

[26] Human Rights Watch, *Fanning the Flames, supra*, p. 21.

[27] Ibid.

[28] 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.

[29] 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.

[30] Human Rights Watch, *Fanning the Flames*, pp. 32–33.

[31] Ibid, p. 33.

[32] 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.

[33] 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.

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

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

[36] Ibid.

[37] 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".

[38] 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".

[39] 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.

[40] 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"*.

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

[42] Article 120 of the *Criminal Code* of Uzbekistan; Article 135 of the *Criminal Code* of Turkmenistan.

[43] 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.

[44] *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).