



PREVENTION OF
TRANSMISSION OF HIV AMONG DRUG USERS
IN SAARC COUNTRIES

RAS/H13

Legal and Policy

concerns related to IDU Harm Reduction in SAARC Countries

Report by



Lawyers Collective HIV/AIDS Unit

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LEGAL AND POLICY CONCERNS RELATED TO IDU HARM REDUCTION IN SAARC COUNTRIES

A REVIEW COMMISSIONED BY UNODC

Prevention of Transmission of HIV
among Drug Users in SAARC Countries
TD/RAS/03/H13

Report by



Lawyers Collective HIV/AIDS Unit

Supported by

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Development



Australian Government

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LIST OF ABBREVIATIONS

| | | | |
|--------|----------------------------------------------------------------|---------|-----------------------------------------------------------------------------------|
| AIDS | Acquired Immune Deficiency Syndrome | MOHFW | Ministry of Health and Family Welfare |
| AIIMS | All India Institute of Medical Sciences | MSJE | Ministry of Social Justice and Empowerment |
| ANF | Anti Narcotics Force | MSM | Men having Sex with Men |
| ART | Anti-Retroviral Treatment | NAC | National AIDS Committee |
| ARV | Anti-Retroviral | NACP | National AIDS Control Program |
| BCC | Behaviour Change Communication | NACO | National AIDS Control Organization |
| BDR | Bangladesh Rifles | NAPCP | National AIDS Prevention and Control Policy |
| BNCA | Bhutan Narcotics Control Agency | NASP | National AIDS and STD Control Program |
| CBN | Central Bureau of Narcotics | NCB | Narcotics Control Bureau |
| CBO | Community Based Organization | NDPS | Narcotic Drugs and Psychotropic Substances |
| CCP | Code of Civil Procedure | NDPSSA | Narcotic Drugs and Psychotropic Substances and Substance Abuse |
| CCrP | Code of Criminal Procedure | NNCB | National Narcotics Control Board |
| CDDA | Cosmetics Devices and Drugs Act | NASROB | National Assessment of Situation and Responses to Opioid/Opiate use in Bangladesh |
| CND | Commission on Narcotic Drugs | NCNCC | Narcotics Control National Co-ordination Committee |
| CNSA | Control of Narcotics Substances Act | NDCLEU | Narcotic Drug Control Law Enforcement Unit |
| DADRP | Drug Abuse Demand Reduction Project | NDDCB | National Dangerous Drugs Control Board |
| DCB | Drug Control Bureau | NGO | Non Government Organization |
| DCP | Drug Control Programme | NIMHANS | National Institute of Mental Health and Neurological Sciences |
| DDA | Department of Drug Administration | NSEP | Needle Syringe Exchange Programs |
| DGHS | Directorate General of Health Services | NWFP | North West Frontier Province |
| DIC | Drop in Centre | PIL | Public Interest Litigation |
| DNC | Department of Narcotics Control | PIP | Program Implementation Plan |
| DOT | Directly Observable Treatment | PNB | Police Narcotic Bureau |
| DPH | Department of Public Health | PNCB | Punjab Narcotics Control Board |
| DRC | Demand Reduction Committee | PODD | Poisons Opium and Dangerous Drugs Act |
| DUs | Drug Users | RIAC | Rapid Intervention and Care Project |
| FATA | Federally Administered Tribal Areas | RRTCs | Regional Resource Training Centres |
| HCV | Hepatitis C Viral | SAARC | South Asian Association for Regional Cooperation |
| HIV | Human Immunodeficiency Virus | SACS | State AIDS Control Society |
| HSPS | Health Sector Programme Support | SRC | Supply Reduction Committee |
| ICCPR | International Covenant on Civil and Political Rights | STD | Sexually Transmitted Diseases |
| ICESCR | International Covenant on Economic, Social and Cultural Rights | STI | Sexually Transmitted Infections |
| IDU | Injection Drug User | TRC | Treatment Review Committee |
| IEC | Information Education and Communication | UDHR | Universal Declaration of Human Rights |
| ILO | International Labour Organization | UNAIDS | Joint United Nations Programme on HIV/AIDS |
| INCB | International Narcotics Control Board | UNDCP | United Nations Drug Control Programme |
| INF | International Nepal Fellowships | UNGASS | United Nations General Assembly |
| IPC | Indian Penal Code | UNODC | United Nations Office on Drugs and Crime |
| LAAM | Levo Alpha Acetyl Methoadol | VCT | Voluntary Counselling and Testing |
| LTTE | Liberation Tigers of Tamil Eelam | WHO | World Health Organisation |
| MOHA | Ministry of Home Affairs | | |
| MMC | Methadone Maintenance Clinic | | |
| MoE | Ministry of Education | | |

PREFACE

AIDS is an extraordinary disease. As such, it requires an extraordinary response.

In South Asia, the HIV epidemic is heterogeneous in nature. Bangladesh, Nepal and Pakistan have HIV epidemics that are primarily driven by injecting drug use. India – a country with one of the largest numbers of people living with HIV/AIDS – features an epidemic in its North Eastern region which is primarily driven by injecting drug use. Bhutan, the Maldives and Sri Lanka are countries with growing number of injecting drug users. The document you are holding in your hands examines whether the laws and policies currently in South Asia are adequate to meet the challenges posed by the threat of HIV/AIDS.

UNODC has been a co-sponsor of the Joint United Nations Programme on AIDS (UNAIDS) since 1999. In 2005, the Programme Co-ordination Body of UNAIDS endorsed the comprehensive approach for prevention of transmission of HIV through injecting drug use in the UNAIDS policy position paper entitled "Intensifying HIV Prevention". This comprehensive approach consists of a wide variety of measures, ranging from drug dependence treatment (including drug substitution treatment), outreach providing injecting drug users with information on risk reduction and referral to services, clean needles and syringes, and condoms, voluntary counselling and testing, treatment of STIs, antiretroviral therapy, and interventions for especially-at-risk populations such as prisoners and sex workers who inject drugs. The comprehensive package of measures also usually includes treatment instead of punishment for persons convicted of minor offenses. It does so because drug dependence treatment constitutes a humane, cost effective alternative, and because incarceration usually increases the risk of HIV transmission.

A consistent body of evidence has established that comprehensive HIV prevention programmes which include needle syringe programmes and oral substitution as part of a comprehensive package reduce drug-related HIV risk behavior (such as needle sharing, unsafe injecting, and frequency of injection). Similarly, there is strong evidence that substitution treatment reduces criminal behavior and illicit opioid use. It also increases treatment retention and improves the overall health status of drug users infected with HIV. These are outcomes which we all seek to promote.

I am confident that the findings of this review will help to build a policy environment in which public health decisions are taken on the basis both of the lessons learnt elsewhere and the cumulative weight of scientific evidence.



Gary Lewis
Representative
Regional Office for South Asia

FOREWORD

Over the last decade or so, attempts have been made to understand social, economic, political and legal factors that determine health. This approach to health has seen increasing application in the context of the HIV/AIDS epidemic. Individual risk behaviors including injecting drug use are influenced by structural elements that include, inter alia, law, mechanisms for its enforcement and its application in Court. To illustrate, the likelihood of an injecting drug user (IDU) reusing contaminated needles to 'fix a shot' is greater where possession of injection paraphernalia can lead to arrest than in jurisdictions where he/she can procure a syringe without being apprehended by the police. Further, laws have a direct bearing on public health policy and programming. Certain effective interventions for reducing harm may not be permitted or closed down for 'want' of legal sanction. On the other hand, if facilitated by law, interventions can be initiated and scaled up to reduce individual vulnerability and promote public health. This is especially true for services like needle-syringe exchange that are crucial to break the chain of HIV transmission among IDUs.

It is against this background that the review of legal and political concerns related to IDU Harm *Reduction* was commissioned by the United Nations Office on Drugs and Crime Regional Office for South Asia (UNODC ROSA) to the Lawyers Collective HIV/AIDS Unit (the Unit) for Project TD/RAS/03/H13 "Prevention of transmission of HIV among drug users *in SAARC countries*", aimed at scaling up HIV interventions among (IDUs) and opiate users in the region. The research is aimed at examining the current legal and policy regime on drug use in SAARC countries i.e. Bangladesh, Bhutan, India, Maldives, Nepal, Pakistan and Sri Lanka in the context of the public health exigency created by IDU and HIV/AIDS. It is expected to inform Project H13 of the legal hurdles in introduction, implementation and scale up of proposed interventions. The report is expected to be the basis for a consultative meeting at the regional level and to serve as a reference document for future advocacy with the drug and HIV sectors.

This report is based on both primary and secondary sources of information. A desk review of international and regional conventions on narcotics and psychotropic substances and country-specific laws, policies and programs on drug use and HIV/AIDS was undertaken. This was followed by site visits and interviews with stakeholders from most countries in the field of drug control and HIV/AIDS including health and narcotics law enforcement officials, NGOs, lawyers and representatives from concerned ministries, U.N and international agencies. The Unit staff visited and met experts in Bangladesh, India, Maldives, Nepal, Pakistan and Sri Lanka. Preliminary drafts of country chapters were sent to country specialists for peer review. Feedback received has been incorporated to the extent possible.

Preparing a report for seven countries on a complex subject like drug use and HIV/AIDS harm reduction law was by no means easy. Firstly, it was extremely difficult to access texts of country legislations, rules and regulations, judicial decisions and, in some cases, even policy documents. While the lack of case law and judgments was a problem for every country, statutes were hard to obtain for Bhutan, Nepal and Bangladesh. Trends in legal practice and actual application of statutes were also difficult to ascertain.

Secondly, interaction with lawyers involved in the field was very limited. In the absence of dialogue with legal experts, it has been difficult for the Unit to authoritatively comment on the legal system including the interpretation of laws, especially of those countries that follow a system different from that in India. Thirdly, information on the nature and extent of drug use among hidden populations including women, prisoners, refugees and illegal immigrants was negligible. Fourthly, expert comments on the draft country chapters were received from only *two* of the seven countries. In the light of limited feedback, some of the data presented may be imprecise or dated. Some other parts of the report still require substantiation.

The Unit would like to express appreciation and thank all those who helped in getting the report together. The Unit would like to thank the National Focal Points for Project H13 who are senior government counterparts from the drug demand reduction and drug law enforcement ministries in all the seven countries for facilitating information collection, arranging visits and organising meetings with key stakeholders. We would also like to thank all the individuals from government and non-government agencies, who provided valuable information and inputs through formal and informal interviews, most of which have been footnoted in the document. The Unit would like to acknowledge and specially thank – Munir Ahmed and Zakiur Rehman in Bangladesh, M. Suresh Kumar, Subba Rao, Luke Samson and Greg Manning in India, Roop Shreshta in Nepal, Tariq Zafar and Nadeem -Ur- Rehman in Pakistan, and, Rohan Edrisinha and Dr. Jayawardena in Sri Lanka for their varied but vital contributions.

The report is built on the shared knowledge and experience of the Lawyers Collective HIV/AIDS Unit, accumulated over the last seven years through litigation, research and advocacy work on public health, human rights and HIV/AIDS in India. The Unit staff who worked on the report are: Anand Grover, Priti Radhakrishnan, Rajesh Ganu, Shivangi Rai and Tripti Tandon. Anand Grover and Tripti Tandon edited the report.

Lawyers Collective HIV/AIDS Unit
India

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The UN Office on Drugs and Crime, Regional Office for South Asia (UNODC ROSA) in partnership with national counterparts from the drug and HIV sectors and with leading non-governmental organizations in the countries of the South Asian Association for Regional Cooperation (SAARC) is implementing project RAS/H13 "Prevention of transmission of HIV among drug users in SAARC countries".

The document on the Legal and Policy concerns related to IDU Harm Reduction in SAARC Countries has been developed after intensive research and with feedback from counterparts and technical experts. UNODC ROSA would therefore like to acknowledge Lawyers Collective HIV/AIDS Unit for authoring this review document. UNODC ROSA would also like to thank national counterparts in drug demand reduction and HIV/AIDS in Bhutan (Ministry of Health), Bangladesh (Department of Narcotics Control and National AIDS/STD Programme), India (Ministry of Social Justice and Empowerment and National AIDS Control Organization), Maldives (National Narcotics Control Board and Department of Public Health), Nepal (Ministry of Home and Department of Health, National Centre of AIDS and STD Control), Pakistan (Ministry of Narcotics Control and National AIDS Control Programme) and Sri Lanka (National Dangerous Drugs Control Board and National STD/AIDS Control Programme) for their support in developing this document.

UNODC ROSA would like to acknowledge the inputs that have been given by civil society partners in this review.

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ABOUT THE REPORT

In the last two decades, countries belonging to the SAARC (South Asian Association for Regional Cooperation) region have seen a dramatic increase in the prevalence of HIV and of injecting drug use. As a result, HIV/AIDS control authorities have implemented harm reduction measures including condom promotion and needle syringe exchange. In view of the positive international experience and some success in countries in South Asia, a need was felt to replicate and expand harm reduction measures. A question has naturally arisen whether these measures are within the bounds of national laws or whether the national laws hinder them and, if so, what can be done about them. This is the broad focus of this document.

Section I of this document sets out the various components integral to a comprehensive harm reduction strategy and assesses these components in the context of criminal law provisions. This section looks at the existing evidentiary base of harm reduction including findings and accepts the opinions of leading UN agencies on the efficacy of harm reduction in preventing the transmission of HIV/AIDS.

Section II provides a broad overview of the applicable international conventions and treaties, specifically examining provisions that impact harm reduction.

Section III of the report analyses the laws, policies and practices on IDU and HIV individually for each of the seven countries, that is Bangladesh, Bhutan, India, Maldives, Nepal, Pakistan and Sri Lanka. The country chapters begin with an estimation of drug use, injecting drug use and HIV/AIDS, as described in current assessments and mapping of risks and vulnerabilities. It then sets out the legal and policy regime in relation to drug use and HIV/AIDS with an emphasis on anti-narcotic legislations. The last segment describes existing programmes and interventions for prevention and treatment for drug use and HIV/AIDS with a focus on IDU harm reduction.

In Section IV, the document discusses emergent issues with respect to law, policy and IDU harm reduction in the South Asian region and indicates potential ways forward.

I. HARM REDUCTION AND THE LAW

1. WHAT IS HARM REDUCTION?

Harm reduction connotes a concept or a proposition underlying measures that aim to prevent or reduce negative health consequences of certain behaviours, without eliminating those behaviours per se. One field in which this idea finds definite application is that of drug dependence. Today, harm reduction is synonymous with specific interventions taken to prevent and mitigate drug related harm, even though the term refers to an overall approach that lays the ground for implementing certain concrete measures. Specifically, the concept is used to describe strategies employed in the context of drug injecting and HIV/AIDS epidemics among drug using populations. Terms such as risk reduction and harm minimization have also gained usage and are often used alternatively.

The defining feature of harm reduction is its pragmatism; the existence of drug use is accepted as it is and priority is accorded to limiting negative health consequences of such use, with blood borne infections and overdose being the most serious immediate harms. This is in contrast to strategies that intend to eradicate drug use altogether which demand total abstinence by drug users. Harm reduction policies set out a hierarchy of achievable goals according highest priority to the most pressing but preventable health hazards such as HIV/AIDS down to a reduction in drug use per se. Because of its obvious emphasis on minimizing harms associated with an activity rather than eliminating the activity itself, harm reduction has been likened to every day risk management strategies such as speed limits, seat

belts and helmet laws that accept the danger in driving as given¹.

Harm reduction assumes immense significance as a public health strategy under conditions where drug users are bereft of social and legal protection and experience severe marginalisation. Interventions embodying the harm reduction approach accept the user and her/his decision to use drugs, without passing a judgment on drug usage. Offering unconditional services to those who do not want to quit, cannot quit or relapse, without condemnation or compulsion, is consistent with the dignity and rights of drug users. Treatment options provided through harm reduction programs enable users to take control of their circumstances and adopt measures for protection of themselves and others. Harm reduction services not only avert immediate harms but also pave the way for drug users to overcome drug dependence in the long term. Harm reduction is founded on an integrationist public health strategy that safeguards community health through preservation of individual rights, particularly of those most vulnerable to disease and debilitation. As such, harm reduction is synergetic with a human rights approach to public health.

1.1 Evolution – Injecting Drug Use and HIV/AIDS

A review of literature suggests that, in the public health scenario, the term harm reduction was coined in 1987. The deployment of harm

1 Hunt et al "A Review of the Evidence–Base for Harm Reduction Approaches to Drug Use" (2003) in *Forward Thinking on Drugs*.

reduction principles in drug abuse management, however, can be traced back to a much earlier period². Significantly in the South Asian context, the practice of supplying opium to registered drug users through government-run outlets during British rule bears a resemblance with present day drug maintenance therapy, one of the components of harm reduction programming³.

Historically though, it was the advent of the HIV/AIDS epidemic and the risk of transmission through injecting drug use that provided an impetus to the development of harm reduction policies and programs. The earliest implementation of harm reduction methods to prevent the spread of blood borne infections like hepatitis and HIV/AIDS among those who injected drugs was reported in Western Europe⁴.

Through the late 1980s and early 1990s, heightening concern about the transmission of HIV/AIDS among drug injecting populations was accompanied with disenchantment with drug programs that professed abstinence only. It was realized that the "threat to individual and public health posed by HIV/AIDS is much greater than the threat posed by drug misuse"⁵. In the absence of alternatives to total withdrawal, drug users were not coming forward to seek assistance for medical conditions like HIV/AIDS that were more pressing than the problem of drug use itself⁶. It was in this public health context that the harm reduction model was evolved, with the primary objective of reducing the likelihood of drug users contracting and/or transmitting HIV/AIDS, hepatitis and other blood borne infections.

While prevention of HIV transmission was, and remains, the principal goal of interventions, harm reduction programs also seek to reduce other negative health conditions arising out of drug use. These include prevention of Hepatitis C (HCV) and other viral and bacterial infections and deaths due to drug overdose. Over a continuum, harm reduction services enable users to receive medical assistance for drug addiction as well as gain access to programs for recovery. On the whole, harm reduction brings drug users closer to health and social services that otherwise remain beyond the community's reach.

1.2 Expansion — Other Vulnerable Groups

Over time, harm reduction methodologies have been applied in relation to other marginalized populations like sex workers and men who have sex with men (MSM) who, like IDUs, remain at serious risk of contracting HIV/AIDS infection. While the predisposing risk factor for these groups is unprotected sex as opposed to unsafe injections in the case of IDUs, structural factors underlying vulnerability — the absence of social and legal protection — remain common. This is especially true in the SAARC region where, like drug users, sex workers and sexual minorities experience considerable social stigma and a punitive legal order that undermines negotiation and self-protection and further results in health afflictions including HIV/AIDS. Principles underlying harm reduction have intuitively informed harm reduction strategies with sex workers, MSM and other vulnerable groups. Provision of health and safety education, voluntary HIV counselling and testing, treatment for sexually transmitted infections, condoms, lubricants and other prophylactic devices to sex workers, MSM and their partners, within a framework that protects rights, fall within the ambit of harm reduction.

2 One report suggests that the British introduced a system of 'heroin control' as early as 1926 and that the role of needle sharing in spreading Hepatitis B among injecting drug users was examined in San Francisco over 30 years ago. See Hunt above n1.

3 Hunt above n1 at 4.

4 A pharmacist is reported to have supplied disposable needles to IDUs in Edinburgh, Scotland as early as 1982-84. The first official needle exchange programme started in Amsterdam in 1984.

5 Hunt above n1.

6 Canadian HIV/AIDS Legal network " Injection drug use and HIV/AIDS: Legal and Ethical issues" (1999), available at ww2.aegis.org/pubs/books/2001/BK011066.html.

2. COMPONENTS OF HARM REDUCTION SERVICES

Harm reduction involves a range of services that enable recipients to modify unsafe drug injection and sexual practices by making health information and precautionary measures available. In the context of IDUs, harm reduction programmes seek to change risk behaviours by offering one or several of the following:

- ◆ Clean needles and syringes
- ◆ Drug substitution treatment
- ◆ Outreach and peer support
- ◆ Information, Education and Communication (IEC)
- ◆ Voluntary counselling and testing (VCT)
- ◆ Condoms
- ◆ Treatment for sexually transmitted infections (STIs)
- ◆ HIV/AIDS related treatment and care
- ◆ Basic Medical Care
- ◆ Treatment for drug dependence⁷

While some services are provided on-site, others may be offered institutionally through referral.

2.1 Clean Needles and Syringes

The sharing and re-use of contaminated needles and syringes have been recognized as primary drivers of HIV and HCV epidemics among IDUs. Provision of clean injection equipment reduces the likelihood of sharing between drug injectors and significantly cuts down exposure to and spread of blood borne infections. Disposable needles can be purchased at pharmacy stores if their sale is not medically regulated. Still, market availability does not translate into actual access to sterile injections for IDUs, many of whom avoid visiting pharmacies on account of fear and stigma or are too poor to be able to afford clean needles for every injection/shot.

7 WHO/UNAIDS/UNODC "HIV/AIDS Prevention among Injecting Drug Users" Advocacy Guide (2004), available at www.who.int/entity/hiv/pub/advocacy/en/advocacyguideen.pdf.

In this context, provision of free needles and syringes becomes imperative to enhance access. The most common mode of delivery is free distribution or supply on an exchange basis i.e. giving sterile needles in return for used ones. Cotton swab, bleach, other disinfectants and cleaning agents may be offered in addition. Needle syringe exchange programs (NSEP) may be stand-alone or a part of larger IDU intervention; they may be offered through outreach and mobile vans, or may be located at a fixed site such as a drop-in centre.

In the SAARC region, clean needles and syringe exchange programs for IDUs exist in cities across Bangladesh, Nepal, India and Pakistan.

2.2 Drug substitution treatment

Unlike NSEPs that were introduced because of the HIV/AIDS epidemic, prescription of medicinal alternatives to opioid-dependent persons has been around long before the threat of blood borne infections was known. As mentioned earlier, in colonial India and Sri Lanka, opium dependents were registered and maintained on the substance by supplying them with fixed quantities at government run opium vendors or boutiques.

The World Health Organisation (WHO) defines drug substitution as *"the administration under medical supervision of a prescribed psycho-active substance, pharmacologically related to the one producing dependence, to people with substance dependence, for achieving defined treatment aims."*⁸

Agents used for replacement/substitution are those that can prevent withdrawal symptoms, suppress craving and diminish the euphoric effects of heroin or other opioid drugs. Additionally, agents having a longer duration of action than the substance that they replace are preferred in that they delay onset of withdrawal and lessen frequency of medical

8 WHO/UNAIDS/UNODC "Substitution maintenance therapy in the management of opioid dependence and HIV/AIDS prevention" Position Paper (2004), available at www.who.int/entity/substance_abuse/publications/en/PositionPaper_flyer_English.pdf.

administration. Methadone is the most commonly prescribed synthetic opiate in drug maintenance programs and has been in use since the late 1950s and 1960s. Buprenorphine substitution was initiated in the 1990s and is fast gaining support among drug treatment practitioners in the SAARC region. Naltrexone and Levo alpha acetyl methadol (LAAM) are some other pharmacological agents offered for maintenance therapy.

Substitution medication is taken orally in a tablet form or syrup, at a clinic or in the presence of health staff. Dosage, frequency of administration and effects vary – depending on the medication and the prescription protocol. In the context of IDUs, substitution therapy enables users to make the switch from injection to oral intake, thus reducing the likelihood of injecting and acquiring HIV/AIDS. Administration under clinical supervision prevents drug overdose. Clinical substitution programs bring users into contact with health staff, facilitating early diagnosis and management of medical problems besides inducing positive health seeking behaviour among clients.

Not only is oral substitution crucial for prevention of HIV/AIDS, it is also a requisite for providing anti-retroviral treatment to opioid dependents infected with HIV/AIDS. WHO recommends the initiation of substitution maintenance among HIV positive drug users to support ARV treatment adherence and medical follow-up.⁹ Recently in 2004, Methadone and Buprenorphine were included in WHO's Essential Drug List, signaling that international experts consider these drugs 'vital' to public health.

Presently, oral drug substitution programs operate in Nepal and India, though the number of users on substitution therapy is very limited. Anecdotal but unconfirmed reports suggest that plans are afoot in Pakistan and Bangladesh to initiate Buprenorphine substitution on a pilot basis.

2.3 Outreach and peer support

Outreach aims to contact IDUs where they congregate and disseminate health and safety information and sometimes even services. Outreach measures are pertinent in settings where drug users are hidden or hard to reach and left out of institutional services. Instead of waiting for drug users to approach drug service centres for help, outreach requires health workers to go into parks, stations, lanes and other IDU ghettos, make contact with IDUs and offer assistance. The range of services provided varies; at some sites, outreach is limited to information provision, while in others places, field staff/outreach workers hand out needles, syringes, bleach, condoms and basic medicines as well. Besides educating clients and delivering services, outreach teams also encourage street users to seek referral for drug treatment facilities, HIV counselling and testing and tertiary care for serious ailments.¹⁰

Peer education entails engagement of current and former IDUs to act as 'change agents' to influence behaviours and norms in the community. The rationale behind a peer-based model is that individuals belonging to the community are better placed to reach out, communicate and affect practices among peers than outsiders, who may not be readily accepted and trusted by the local community. Projects employing the peer education strategy select and train former or active IDUs in various aspects of harm reduction programming, including behaviour change, communication, counselling, distribution of condoms and injection equipment, abscess management and treatment referral. Peer workers may be volunteers or salaried staff.

Most community-based IDU harm reduction programs in the SAARC region, including in

9 WHO/UNAIDS/UNODC Position Paper above n8.

10 WHO/UNAIDS/UNODC "Evidence for Action on HIV/AIDS and Injecting Drug Use: Reduction of HIV Transmission through Outreach" Policy Brief (2004), available at <http://www.who.int/hiv/pub/idu/idupolicybriefs/en/>.

Bangladesh, India, Maldives, Nepal and Pakistan, employ outreach teams and peer workers.

2.4 Information, Education and Communication (IEC)

Education of drug users on safe injection and sexual practices is an essential component of harm reduction programs. Typically, IDUs are given information *on how to inject safely*, including on the use of sterile syringes, the importance of non-sharing, safe spots for injecting, prevention and management of abscesses and avoidance of overdose. Safe sex messages and the correct way to use a condom are also included in harm reduction IEC. Written or graphic materials such as leaflets, posters and video films, and/or group education and interpersonal communication instilling safer practices are some of the commonly used media. Credible and comprehensive contents as well as delivery of messages in a 'user friendly' manner have been recognized as essential attributes of successful IEC programming.¹¹ In the context of IDUs, drug education and safe injection is weaved into harm reduction projects and is rarely a stand-alone activity.

In general, it has been observed that IDU interventions in South Asian cities tend to rely more on interpersonal communication than on development and use of educational material for behaviour change. This is based on field work carried out by the Lawyers Collective HIV/AIDS Unit ("the Unit") for this review. None of the harm reduction projects visited by the Unit staff had any IEC material specific to IDU and HIV. It was observed that the IEC materials developed by government agencies tended to advise the use of disposable syringes in hospital settings *only*. NGOs too did not have published materials i.e. posters, flip books etc. that described how to inject safely.

11 The Centre for Harm Reduction Manual for Reducing Drug Related Harm in Asia (Macfarlane Burnet Centre for Medical Research and Asian Harm Reduction Network, 2003) at 36.

2.5 Voluntary Counselling and Testing (VCT)

Though not a typical harm reduction activity, provision of counselling and voluntary HIV testing is being increasingly seen as an important constituent of harm reduction, in the light of research findings that drug users do not have access to means for finding out their HIV status.¹² VCT may be offered on site or through referral and linkages with institutional services like testing centres in public hospitals. Maintenance of confidentiality and informed consent are crucial, as is client engagement through pre- and post-test counselling.¹³ Globally, mandatory testing of high-risk populations like IDUs has been rejected as an HIV/AIDS prevention and control strategy. At the same time, experts are faced with the challenge of promoting VCT within community settings, given IDUs reluctance to approach institutional health centres for fear of public identification and discrimination.

2.6 Condoms

Promoting the use of condoms among sexually active populations is one of the main strategies to prevent sexual transmission of HIV/AIDS. Historically, condom promotion efforts were focused on groups such as sex workers and MSM, who are exposed to HIV/AIDS because of unprotected sex with multiple partners. Little attention was paid to the sexual behaviour of drug users and the effect of intoxicants on sexual activity, until behavioural surveys revealed that IDUs are – 1) sexually active, 2) engage in sex with regular and non-regular partners including sex workers, and 3) use condoms infrequently. Some situational assessments found users, especially women, selling sex to support drug use. Another intersection between drug use and sexual practice has been

12 Rapid Situation Assessments (RSA) done in 5 Indian cities and the national survey of drug use in India show that very few users have undergone counselling and voluntary testing for HIV/AIDS. Similarly, in Pakistan, few users access HIV/AIDS counselling and testing services.

13 The Centre for Harm Reduction Manual above n11 at 40.

observed in sex work settings where clients and sex workers reportedly have unprotected sex under the influence of drugs or alcohol. More recently, reports of widespread methamphetamine use among gay men and the rise in rates of STI/HIV infection in the United States have caused alarm among public health agencies. In India and Nepal, rapidly rising rates of HIV infection among partners and spouses of IDUs calls for renewing focus on sexual behaviours of drug using populations.¹⁴

As far as distribution is concerned, condoms may be offered free and/or sold, either openly or discreetly through vending machines, depending on the social context. Condom promotion may also be legally restricted; some countries require a medical prescription for purchasing condoms and other contraceptive devices.¹⁵ As part of HIV prevention and harm reduction programs, condoms may be offered free or at subsidized rates through social marketing.

Officially, condoms are part of National AIDS prevention programs in Bangladesh, Bhutan, India, Nepal, Pakistan and Sri Lanka. This formal acceptance has, however, not translated into increased availability and access to condoms for sexually active populations across the region.

2.7 Treatment for STIs

Convergence of sexual and drug using risks among drug using populations has led interventionists to pay greater attention to sexual health and safety. Some harm reduction programs have extended facilities for screening, management and treatment of sexually transmitted infections to IDUs and their partners.¹⁶ In some places, STI treatment is offered on site and in others, through referral to medical institutions.

14 Studies have shown a 45% infection rate among non-injecting female partners of IDUs in Manipur. See further Country Analysis – India below.

15 See Country Analysis – Maldives below.

16 SHARAN in New Delhi offers STI treatment on site. So does CARE in Bangladesh.

2.8 HIV/AIDS related Treatment and Care

Access to HIV treatment is emerging as a critical issue in countries facing IDU-driven HIV epidemics, as also in places where a significant proportion of injecting users are HIV positive. The WHO has included HIV-related treatment and care as a component of harm reduction programs by noting the significant prevention effects that it may result in.¹⁷ HIV/AIDS treatment and care includes medication for and management of opportunistic infections, anti-retroviral therapy, post-infection counselling, clinical as well as community-based care and support that enable IDUs living with HIV/AIDS to cope with the infection. A report examining treatment access for HIV positive injection users notes:

“Case studies from around the world demonstrate that well-designed, supportive programs that address the particular needs of injection drug users can help all individuals adhere to antiretroviral therapy, take advantage of appropriate harm reduction services and enjoy improved quality of life.”¹⁸

Despite evidence of the benefits of therapy and treatment compliance, HIV positive drug users remain excluded from ARV treatment programs. India is the only country in the region to offer ARV therapy through the public health sector. Even here, the number of HIV positive IDUs on treatment is dismally low.

2.9 Basic Health Care and Allied Services

Drug injection-related health problems are aggravated by the absence of basic health services, poor hygiene and sanitation. In many cities of

17 WHO “Harm Reduction approaches to Injecting Drug Use” (2004), available at <http://www.who.int/hiv/topics/harm/reduction/en/print.html>.

18 Open Society Institute “Breaking Down Barriers: Lessons on providing HIV Treatment to Injection Drug Users” (New York, July 2004); available at http://www.soros.org/initiatives/ihrd/articles_publications/publications/arv_idus_20040715/Breaking_Down_Barriers.pdf.

South Asia, IDUs live in abysmal conditions of poverty, ill-health and extreme neglect. Abscesses and gangrene are common among injectors as are communicable diseases like tuberculosis. In this context, provision of primary health care, abscess and wound management and sanitation facilities like cleaning and washing becomes imperative for securing improvement in health and overall well-being. At a harm reduction project site in Delhi, HIV prevention services are linked to a Directly Observable Treatment (DOTs) Centre for Tuberculosis. A drop-in centre for IDUs in Lahore offers nutritional support besides providing medical services. For poor and disadvantaged IDUs, access to food, health and sanitation facilities acts as a 'pull' to harm reduction project sites. Infact, clients attending basic medical services often outnumber participation in specific harm reduction services.

2.10 Treatment for Drug Dependence

IDU harm reduction programs are often linked to drug demand reduction services, including detoxification, in-patient treatment, counselling and rehabilitation. Clinical detoxification may be offered institutionally or in community settings through camps, although the latter approach has not seen much success. Drug treatment centres may additionally, directly or through referral, provide prolonged support to recovering drug users. Psychosocial assistance may be in the form of counselling, half-way homes, skill building and economic activity, all of which enable clients to overcome dependence and return to functional lives.

Drug treatment facilities exist in most countries in the region but fall way short of demand.

2.11 Other Measures

Other strategies that have or are presently being employed under the harm reduction umbrella include *safe injection/consumption rooms* and

heroin prescription.¹⁹ The underlying feature is permitting substance use under strictly regulated conditions in order to prevent the harms of illicit use.

Safe injection rooms are medically supervised spaces where IDUs are allowed to inject drugs in the presence of medical staff. Consumption rooms are similar facilities for people who smoke, rather than inject. As the name suggests, heroin prescription involves medical prescription of pharmaceutical heroin (Diamorphine) to drug users as a substitute for illicit heroin. Benefits expected from regulated drug consumption are promoting injection safety, minimizing exposure to infections like HIV and Hepatitis C, reducing risk of overdose, facilitating contact with health workers, reducing illicit drug use and also drug-related crime.²⁰ The employment of safe injection rooms is limited to some Scandinavian countries, Australia, New Zealand and Canada.

3. HARM REDUCTION – EFFICACY

Over the last few years, attempts have been made to scientifically investigate the efficacy of harm reduction interventions in attaining public health objectives, namely reduction in HIV risk behaviours and HIV infection among IDUs. Other outcomes evaluated among study participants include drug-related morbidity and deaths, health seeking practices including enrolment in drug treatment facilities, unintended or negative consequences such as impact on drug-related crimes, and the cost effectiveness of harm reduction services. This evidence base indicates that IDU harm reduction works.

3.1 NSEP

Evidence gathered to assess the impact of NSEP in averting HIV transmission among drug injecting

¹⁹ Hunt above n1.

²⁰ Hunt above n1.

populations is strong and supportive. A review of scientific evidence for NSEP concludes that provision of sterile injection equipment to IDUs prevents sharing and re-use of contaminated needles and reduces exposure to HIV infection.²¹ A study in Australia affirmed the effectiveness of NSEPs in reducing the incidence of HIV and HCV and demonstrated that the direct costs of treatment saved by avoidance of HIV and HCV infections outweighed the costs of providing sterile injection equipment to IDUs.²² The WHO has noted the effectiveness of NSEPs in over 200 studies conducted in different parts of the world.²³ In the South Asian region, the containment of HIV infection among IDUs in Dhaka, Bangladesh has been attributed to the NSEPs.²⁴ Unintended or negative consequences of providing sterile needles to IDUs are rarely reported. It is well established that NSEPs do not result in increasing consumption of illicit drugs among IDUs or prompt non-injecting drug users to inject. In one of its recent papers reviewing the effectiveness of sterile needle and syringe programs in reducing HIV/AIDS among IDUs, the WHO concludes:

1. *There is compelling evidence that increasing the availability and utilization of sterile injecting equipment by IDUs reduces HIV infection substantially.*
2. *There is no convincing evidence of any major, unintended negative consequences.*
3. *Needle syringe programmes are cost-effective.*
4. *Needle syringe programs have additional and worthwhile benefits apart from reducing HIV infection among IDUs.*²⁵

21 Hunt et al "Reducing Drug-Related Harms to Health: An Overview of the Global Evidence" Report 4 (Beckley Foundation Drug Policy Programme)

22 Report of the Australian Government "Return on Investment in Needle Exchange and Syringe Programs Report" (2002), available at <http://www.health.gov.au/pubhlth/publicat/hac.htm>.

23 WHO/UNAIDS/UNODC "Evidence for action on HIV/AIDS and Injecting Drug Use: Provision of Sterile Injecting Equipment to Reduce HIV Transmission" Policy Brief (2004)

24 WHO/UNAIDS/UNODC, Advocacy Guide above n7 at 5.

25 WHO, "Effectiveness of sterile needle and syringe programming in reducing HIV/AIDS among injecting drug users" Evidence for Action Technical Papers (2004)

3.2 Oral Substitution

Globally, Methadone is the most extensively researched opioid substitute. Reviews conclude that Methadone is a safe and effective replacement for opioid dependent users.²⁶ Sublingual Buprenorphine, though researched less extensively, has emerged as a promising option for heroin users with few side effects and mild withdrawal symptoms. Assessments suggest that drug users enrolled in oral substitution and drug maintenance programs are able to return to socially and economically functional lives. From the drug user community's perspective, substitution programs have been associated with substantial reduction in illicit drug use, criminal activity, deaths due to overdose and behaviours with a high risk of HIV transmission.²⁷

In recent years, international agencies working on drug control and health have noted the merits of substitution therapy. A joint position paper on 'substitution maintenance therapy in the management of opioid dependence and HIV/AIDS prevention' released by WHO, UNAIDS and UNODC acknowledges:

*"Substitution maintenance therapy is one of the most effective treatment options for opioid dependence. It can decrease the high cost of opioid dependence to individuals, their families and society at large by reducing heroin use, associated deaths, HIV risk behaviours and criminal activity. Substitution therapy is a critical component of community-based approaches in the management of opioid dependence and the prevention of HIV infection among IDUs."*²⁸

The WHO summarizes the evidence for substitution therapy in the following words:

"The scientific evidence is reflected in the growth in provision of substitution maintenance

26 Hunt above n21.

27 Hunt above n21.

28 "Substitution Maintenance Therapy in the Management of Opioid Dependence and HIV/AIDS Prevention" above n8.

*treatment services in most countries of the European Union and in some countries of Eastern Europe, Asia and the Americas, mirrored by a reduction in HIV transmission rates or the maintenance of low sero-prevalence levels. The review also found that investment in drug-dependence treatment, particularly substitution maintenance treatment was cost-effective in comparison with the costs of later treatment of HIV/AIDS and related diseases."*²⁹

Significantly, in 2004, the agency recommended the inclusion of Methadone and Buprenorphine in the WHO list of Essential Medicines to ensure availability of "safe and effective treatments for infectious and chronic diseases which affect the vast majority of the world's population."³⁰

3.3 Outreach and Peer Engagement

Experience and research has shown that outreach and peer education are effective means of accessing IDUs and enhancing voluntary enrolment in harm reduction services. Specific outcomes of outreach programs studied include increased cessation of injecting drug use, increased needle disinfection and condom use and increased entry into drug dependence treatment programs.³¹ The WHO concludes:

*"Outreach is an effective strategy for reaching hard to reach, hidden populations of IDUs and provides the means for enabling IDUs to reduce their risk behaviours; a significant proportion of IDUs receiving outreach based interventions reduce their risk behaviours, drug using, needle and sexual practices and increase their protective behaviours; changes in behaviours have been found to be associated with lower rates of HIV infection."*³²

29 WHO/UNAIDS/UNODC "Evidence for Action on HIV/AIDS and Injecting Drug Use: Reduction of HIV Transmission through Drug-Dependence Treatment" Policy Brief (2004), available at www.wpro.who.int/health_topics/harm_reduction/publications.htm.

30 Hunt above n21.

31 WHO/UNAIDS/UNODC Policy Brief above n10.

32 Hunt above n21.

Peer-led interventions were also found to be effective in promoting safer drug injection practices among IDUs.³³ The role of outreach teams and contribution of peers in modifying group behaviours and bridging the gap between drug users and drug-related services is now widely recognized.

3.4 IEC

Despite their widespread use for HIV/AIDS prevention programs, research examining the effectiveness of IEC materials is scant. IEC messages are rarely stand-alone; information and advocacy is dovetailed into other clinical and community services thereby making it difficult to evaluate the impact of IEC separately. Still, IEC is considered a valuable supplement to IDU harm reduction services.

3.5 Condoms

Scientific proof for condoms is less compelling as compared to other interventions like clean needles. Notwithstanding the lack of conclusive evidence, condoms remain the most effective means of protection against sexual transmission of HIV/AIDS.

4. THE INTERFACE BETWEEN LAW AND HARM REDUCTION

Predominantly, the use of narcotic drugs is subject to legal prohibition. Harm reduction measures, because they relate to drugs and persons who use them, are affected by law. Criminal and narcotics-related statutes both have a bearing on harm reduction; legal strictures may directly oppose or restrict measures for prevention, treatment and care and/or create conditions where harm reduction interventions are unable to reach

33 The Centre for Harm Reduction Manual above n11 at 38. See also UNAIDS/AHRN/UNODC "Preventing HIV/AIDS among drug users: Case studies from Asia", Regional Task Force on Drug Use and HIV Vulnerability (2003) at 32, available at www.unaids.org/html/pub/Publications/IRC-pub03/AsiaDrugUsers_en_pdf.pdf.

communities most at risk. Before examining the impact of such laws on harm reduction, it is important to understand relevant concepts in penal and drug laws.

4.1 Penal Offences

Crimes discussed below are offences of a generic nature potentially invoked by certain harm reduction activities. Originally, these criminal acts were public and moral wrongs made punishable by judges. Crimes pronounced by judges as such became a part of common law;³⁴ some were later codified in statutes such as the Penal Code³⁵ introduced by the British in 1860 in undivided India and later adopted in other English colonies. The original Indian Penal Code forms the basis of present day Penal Codes of Bangladesh, India and Pakistan.³⁶ The Penal Code of Sri Lanka is greatly similar, though not identical.

(a) Abetment

Black's Law Dictionary defines abetment as the act of encouraging, inciting or aiding another to commit a crime. A person is said to abet a crime when s/he aids the perpetrator in the commission of that crime. Persons giving any kind of assistance to the criminal attract liability if abetment of an offence is recognized as an offence in itself.³⁷ Complicity in crime by aiding, abetting, counselling or procuring the commission of an offence is punishable even without actual commission of crime.

34 The common law comprises the body of law developed first in England by judicial precedent but not written in any formal statute. It comprises the legal principles that derive from unwritten custom in England as applied and articulated by the Courts. Common law is the basis of the legal system in England, Commonwealth countries including Canada, Australia and New Zealand and the United States. Erstwhile British ruled territories in Africa and Asia also follow the same system. Civil law is an alternative legal system derived from Roman law and commonly used in Europe and South America. In South Asia, Bangladesh, India and Pakistan are common law countries whereas the legal system in Nepal, Sri Lanka and Maldives is partly influenced by English common law and partly by civil law.

35 The Indian Penal Code, 1860 (Act 45 of 1860)

36 The three penal codes are practically the same barring Amendments in the three countries in the post colonial period.

37 Ratanlal and Dhirajlal Law of crimes

At common law, there is a distinction between the 'principal' i.e. the person accused of committing the substantive offence and the 'accessory'³⁸ i.e. the person who aided and abetted or incited the commission of the offence. Those who aid, abet, counsel or procure the commission of an offence are designated as 'secondary' parties, whose liability is derived from the liability of the principal or the perpetrator.³⁹ Secondary parties are liable when and where the offence aided, abetted, counseled or procured is committed.⁴⁰ Abetment in itself, however, does not involve the actual commission of the crime abetted. It is a separate crime.⁴¹

A charge of abetment is proved when the prosecution establishes that the abettor has:

- ◆ Instigated the doing of a thing,⁴² or
- ◆ Engaged in a conspiracy for doing that thing,⁴³ or
- ◆ Intentionally aided the doing of that thing⁴⁴ by an act or illegal omission.⁴⁵

Mere giving of an aid does not make the act an abetment of offence, if the person who gave the aid did not know that an offence was being committed or contemplated. The existence of mens rea – knowledge and intention – is essential to the crime of abetment.

(b) Criminal conspiracy

Black's Law Dictionary defines criminal conspiracy *as an agreement or confederacy of two or more*

38 Glanville Textbook of Criminal Law 2ed (Stevens and Sons, London, 1983)

39 Smith and Hogan Criminal Law 7ed at123. See also Glanville above n39 at 368.

40 Smith above n40 at 124.

41 Ratanlal above n38 at 404; See also Gurbachan Singh v. Satpal Singh AIR 1990 SC 209 at 211

42 Instigation refers to actively suggesting, stimulating or insinuating another person to perform an illegal act or omission.

43 Abetment by conspiracy requires (1) an agreement between persons and (2) doing of the act or omission agreed to by such persons.

44 A person abets by aiding, when by any act done either prior to or at the time of, commission of an act, he intends to facilitate and does in fact facilitate the commission thereof.

45 Section 107, Indian Penal Code. See also Saju v. State of Kerala (2001) 1 SCC 378.

persons to do a criminal or unlawful act or to do a lawful act in an unlawful or criminal manner. In some jurisdictions, an overt, preparatory act in furtherance of the confederacy is required. However, the crime may not be committed pursuant to the conspiracy. The agreement by itself constitutes the offence.

The essence of criminal conspiracy is the concurrence evinced by a meeting of minds between the conspirators to do an illegal act. The agreement may be expressed orally or in writing or may be implied. The offence lies in the very agreement to commit a criminal offence irrespective of whether the offence agreed to between the persons is executed or not.⁴⁶ In contrast, abetment must result in the commission of the offence abetted.

(c) Common intention

A criminal act done by several persons in furtherance of a common intention makes each of such persons jointly liable for the crime. The principle set out in this provision is that persons acting in concert for the commission of an offence must be liable for the act as if each person committed the act individually.⁴⁷ The essential ingredients to establish joint liability of the accused are that the accused (1) shared a common intention and (2) participated in the crime.⁴⁸

The element of participation in the crime makes persons accused of committing offences with a common intention '*principal parties*' whereas persons aiding or abetting the crime are considered '*accessories*' or secondary parties to the crime. The difference between common intention and criminal conspiracy lies in the participation of the accused in the commission of the offence. While common intention requires participation of the accused in the criminal act executed with a common intention, being a party

to the agreement without physical involvement in the crime is sufficient to constitute the offence of criminal conspiracy.

The provision for criminal acts done in common intention does not create a distinct offence and has to be read with another substantive penal provision.

(d) Attempt

An attempt to commit an offence,⁴⁹ even without actual commission of the offence, is punishable in itself.⁵⁰ Attempt is defined as intent to commit a crime coupled with an act taken toward committing the offence. The requisite elements of an 'attempt' to commit a crime are: (1) an intent to commit it, (2) an overt act toward its commission, (3) failure of consummation, and (4) the apparent possibility of commission.⁵¹

4.2 Drug Offences

Acts discussed below are crimes specific to narcotics and psychotropic substances that interfere with IDU harm reduction interventions. The substantive offence as well as the penalty for these acts is contained in anti-narcotic laws and/or may be delineated in a penal statute expressly for dangerous/controlled substances.

(a) Possession

Possession of narcotic drugs, with the exception of possession for medical and scientific purposes, is proscribed under drug laws. 'Possess' means actual control, care and management of the drug.⁵² The accused is said to be in possession of a prohibited substance when s/he is (1) aware of its presence,

46 Bimbardhar Pradhan v. State of Orissa AIR 1956 SC 469.

47 Section 34, Indian Penal Code.

48 Gurdatta Mal v. State of UP AIR 1965 SC 257.

49 Attempt to commit an offence is said to begin when the preparations are complete and the culprit commences to do something with the intention of committing the offence and which is a step towards the commission of the offence. See Abhayanand Mishra v. State of Bihar AIR 1961 SC 1698.

50 Section 511, Indian Penal Code.

51 State v. Stewart, Mo.App 537 S.W.2d 579 at 581.

52 Collini v. State Tex.Cr.App 487 S.W.2d 132 at 135.

(2) can access it readily, and (3) exercises dominion or control over it.⁵³

The quantum of punishment depends on quantity and nature of substance found. Additionally, in some countries, like Sri Lanka, possession of drug paraphernalia without a prescription attracts penalties.

(b) Distribution

Distribution of prohibited substances has been categorized as an offence in most anti-narcotics legislations. In an English case, judges held that 'a person distributes a dangerous drug when he sells, transfers, gives or delivers to another, or leaves, barter or exchanges with another, or offers or agrees to do the same.'⁵⁴ Distribution includes but is not limited to a transactional exchange of prohibited substances.

(c) Supply

Supplying narcotic and psychotropic substances is prohibited. The offence is mostly targeted at peddlers and illicit suppliers. Black's law dictionary defines 'supply' as - to furnish with what is wanted; available aggregate of things needed or demanded; anything yielded or afforded to meet a want; and the act of furnishing with what is wanted.⁵⁵

(d) Use and consumption

Use of controlled/illicit substances, with the exception of use for medical and scientific purposes, constitutes an offence under drug laws. Use may be construed narrowly to mean 'intake' of drug by smoking, injecting or ingesting, or it may refer to all the other purposes for which narcotics and psychotropic substances are employed. Drug laws in some countries make a distinction between

'use' and 'consumption',⁵⁶ the latter being defined as personal consumption through smoking, inhaling, ingesting, snorting, and any other mode. The offence of use and/or consumption is primarily targeted at drug users.

(e) Allowing premises to be used for commission of offence

Most narcotics control statutes include a provision that makes it an offence for an owner or occupier to sublet her/his premises for the commission of offence. Knowledge on the part of the accused that the premises are used for activities that are in contravention of the law must be proved.

4.3 Impact of Law on Harm Reduction Interventions

The legal concepts discussed above have a significant effect on harm reduction measures. Specific interventions may attract the application of penal provisions. Simultaneously, some enactments may be invoked to discontinue certain services.

The interface between law and harm reduction is illustrated below:

Illustration 1

Government of country A receives a grant from Donor agency D pursuant to an agreement between the two for reducing the transmission of HIV/AIDS among IDUs. The government subcontracts IDU harm reduction projects to local NGO X. Having received funds from the government, Y, head of NGO X, rents out premises from owner L for setting up a needle syringe exchange programme (NSEP). Y hires staff W1, W2, W3 and W4 for providing sterile injection equipment to IDUs at risk of HIV/AIDS.

53 State v. Hornaday 105 Wash.2d 120, 713 P. 2d 71 at 74.

54 State v. Schofill 63 Haw. 77, 621 P.2d 364 at 368.

55 Clayton v. Bridgeport Mach. Co. Tex.Civ.App., 33 S.W.2d 787 at 789.

56 See Section 2 (xxviii) of the Narcotic Drugs and Psychotropic Substances Act, 1985 of India.

W1 dispenses new syringes and collects contaminated ones. W2 records the data including the name, age and other description of clients and the number of syringes handed out on each visit. At the time of exchange, W1 and W2 answer questions that clients have on ways to minimize risks such as how to load the syringe, safer spots for injecting and appropriate quantity to avoid overdose. Through outreach, W3 and W4, who are ex-drug users themselves, impart information to persons injecting drugs on the importance of using sterile injection equipment. W3 and W4 also encourage drug users to visit the NSEP and exchange used needles for new ones. Occasionally, they hand out disposable needles to those unable to visit the centre. The injection equipment offered at the premises is utilized by IDUs to inject drugs.

The police receive a complaint about the growing menace of drug consumption, which is a punishable offence in Country A.

- Drug users including IDUs receiving services from NGO X can be arrested and prosecuted for illicit consumption.
- NGO X may be seen as 'facilitating' illicit drug use among its clients. The prosecution could argue that NGO X is 'intentionally' aiding the crime of drug use by providing information and injecting tools to IDUs to inject drugs. More specifically, W1, who dispenses the needles may be prosecutable for offering the 'aid' i.e. injection for drug use. Provision of information and educational materials on safe injection by W2, W3 and W4 may be construed as 'instigating' principal offenders, especially if such literature is seen as encouraging drug use among dependent users and

others. Y may be held responsible for engaging other persons i.e. W1, W2, W3 and W4 in a 'conspiracy' to distribute needles. All can be accused of abetment of illicit drug consumption. The prosecution may hold them jointly liable for criminal act done with common intention.

- L, the owner of the premises may be accused for allowing premises to be employed for illegitimate purposes, namely aiding and abetting illicit use.
- The agreement between NGO X and Government A and, possibly, between Government A and Donor D may be construed as criminal conspiracy.
- If possession of drug use paraphernalia were prohibited in country A, the NSEP run by NGO X would be in contravention of the law in no uncertain terms. IDUs obtaining syringes as well as workers of suppliers of sterile injections (W1, W3 and W4) could face arrest.

In addition to arresting harm reduction interventionists, the police may exercise investigative powers and raid the NSEP. W2 may be asked to hand over confidential clients records. Stocks of disposable injection equipment may be seized.

It is not uncommon for policy makers and government officials to cite legal reasons to oppose health interventions like NSEPs. Till date, no existing harm reduction intervention for IDUs has been accused of abetment in a Court of law. Notwithstanding the absence of a legal precedent, prosecution of project functionaries under abetment laws is more than a mere theoretical possibility.

Illustration 2

Physician P runs a Methadone clinic for heroin dependent users in Country B. At the clinic, S1 receives the consignment of Methadone from the pharmacist. P examines attendees and prescribes the dose after explaining the administration and effect of Methadone. S2 administers the drug. Occasionally, supplies for a week are provided if the client is travelling or is unable to visit the facility to receive the dose.

During the course of tracking illicit drug traffic and sales, police receive information about the Methadone clinic. Drug use is a punishable offence in country B. Methadone is a prohibited narcotic drug.

- The Methadone clinic is illegal. Drug users enrolled in the clinic can be booked for illicit consumption and possession.
- S1 and S2 can be arrested for possession of illicit substance. P, S1 and S2 may also attract penalties for supply and distribution of a prohibited substance.

No case of harm reduction programme workers including staff at maintenance/substitution clinics being charged with possession/delivery/supply of illicit drugs has been recorded thus far. Drug users, however, continue to be booked and arrested for possession. While a direct impact on harm reduction interventions may not be evident, the possible apprehension of clients and attendees at substitution clinics will diminish access and reduce coverage of programs. Narcotics indictment authorities maintain that in the light of these provisions, Methadone and/or Buprenorphine substitution programs cannot receive official permission.⁵⁷

57 Interview with NFPs in Pakistan, Bangladesh, Sri Lanka.

Illustration 3

Country C has a significant population of drug dependent users incarcerated in prison. A survey carried out by jail authorities indicates that sexual activity among inmates is high. Alarmed at the potential spread of HIV/AIDS, M, jail superintendent proposes to make condoms available to prisoners. M also puts out IEC material on safer sex.

Legal authorities question the move because sodomy is crime in Country C. Offering condoms to men who have sex with other men amounts to abetting the crime of sodomy.

The legality of provision of condoms can be questioned in countries where consensual sex between adults of the same sex and/or not married to each other is a criminal offence. Handing out condoms to persons having sex outside marriage where adultery is a punishable offence or distributing condoms and lubricants to MSM where sodomy is an offence can be seen as abetment of the principal offence of adultery or sodomy. Similarly, educational material on correct and consistent condom use during anal sex may be construed as encouraging the crime of 'unnatural sex'.

In 2001, in Lucknow, India, police raided offices of non-governmental agencies working on male sexual health and HIV prevention among MSM. Staff members were arrested and detained, *inter alia* for abetment to commit a crime of sodomy.⁵⁸ More recently, in Kolkata, India, public authorities raised objections against the display of information on same sex relations, which was considered inciteful.⁵⁹ In India, authorities resisted distribution of condoms in Tihar jail in Delhi on the ground that it amounts to abetment

58 Lawyers Collective, "Legislating an epidemic: HIV/AIDS in India" (Universal publications, New Delhi, 2003) at 91.

59 Amitie case in Kolkata (email correspondence on file with authors).

of the offence of unnatural sex. Local police are known to have objected to peer workers supplying condoms to sex workers and MSM as it 'encourages criminal activity'.⁶⁰

Illustration 4

Alarmed at the extent and severity of drug dependence among school and college attendees, Health Authorities in Country D announce a policy to offer drug treatment services including counseling, detoxification and medication to overcome dependence in University campuses. Critics oppose this 'soft treatment' meted out to drug users, who are seen as corrupting other youth. The Narcotic law in Country D mandates punitive sanctions against drug users namely, arrest, trial, conviction and imprisonment of persons accused of drug consumption. A petition is filed challenging the government's actions.

- *The policy of offering treatment to drug users may be struck down, as it stands contrary to statutory provisions.*

- *The drug treatment centers may face legal resistance and be closed down on judicial orders.*

- *Providing treatment to drug users may be seen as offering 'immunity' to the accused. In the absence of a legal provision or rule supporting such practice, the Health Department's actions may be construed 'invalid'.*

5. CONCLUSION

The legal response to drug use, as defined in drug laws, is underlined by a policy of prohibition to be executed through penal instruments. Harm reduction programmes, on the other hand, promote safety and avert risks while tolerating substance use per se. This has resulted in a genuine contradiction between legal and public health approaches to drug use. While penal law relates to a drug user as an offender, health authorities regard substance dependence as a manageable medical condition. Non-punitive interventions for drug users, in particular, programmes that primarily address drug related risks and not drug use itself border on the brink of illegality. Furthermore, certain programmatic measures such as NSEP, oral drug substitution and condom supplies stand in direct and obvious conflict with criminal law. It is in this incongruous backdrop that IDU and HIV/AIDS containment efforts presently exist.

⁶⁰ Human Rights Watch, "Epidemic of Abuse: Police Harassment of HIV/AIDS Outreach Workers in India", Vol. 14, No. 5 (July 2002). See also Human Rights Watch, "Ravaging the Vulnerable: Abuses against persons at high risk of HIV infection in Bangladesh" Vol 15, No. 6 (August 2003).

II. INTERNATIONAL LEGAL FRAMEWORK

I. INJECTING DRUG USE PROGRAMS: CO-EXISTENCE AND CONFLICTS WITH NATIONAL LEGISLATIONS

The prevention of transmission of the human immunodeficiency virus (HIV) and related hepatitis amongst and by (IDUs) is critical. Drug use, particularly injecting drug use, is a pervasive and increasing phenomenon in the SAARC region. As HIV infection rates dramatically increase in the region for IDUs and their needle-sharing and sexual partners,¹ a natural response has evolved in particular communities. Specifically, to reduce chances of HIV transmission, programs have gained momentum, such as condom distribution, needle exchange programs, IEC, outreach and peer support, voluntary counselling and testing, and treatment and care and support. Recognizing the grave medical nature and consequences of drug dependency, there is also a shift in programmatic support towards implementing, or giving serious consideration to the idea of drug substitution therapy.

Such programmatic shifts towards harm reduction programs are in line with government policies and law enforcement actions that recognize and work with the realities of IDUs, HIV-positive and affected persons. Similarly, the United Nations Declaration of Commitment on HIV/AIDS and the International Guidelines on HIV/AIDS and Human Rights specifically support harm reduction as a prevention strategy.² The WHO/UNAIDS/UNODC

have reported that drug dependency is a medical condition, and that providing drug substitution therapy is treatment for that medical condition.³ Furthermore, these leading authorities have explicitly articulated the proposition that drug substitution therapy is in consonance with the existing international law regime on narcotic drugs and psychotropic substances.

However, due to a number of factors, national legislations on narcotic drugs and psychotropic substances do not specifically permit or recommend harm reduction strategies, as these legislations came into force before the advent of HIV/AIDS. Laws have not been amended to keep pace with the dramatic increases in IDU and HIV worldwide, primarily for two reasons: (1) a perception amongst some that compliance with the international narcotics conventions requires legislation that does not permit or recommend harm reduction strategies and (2) a perception by some that such harm reduction programming may not be contextually, that is, culturally, socially, politically, religiously or economically – appropriate for SAARC countries. Some however claim that harm reduction policies, laws and programs have existed in a “western” context and should therefore be replicated within the SAARC context before determining efficacy or appropriateness. With the large number of IDUs and HIV positive

1 Sterile syringe and condom usage are low within this risk group.
2 United Nations General Assembly Special Session “Declaration of

Commitment on HIV/AIDS” (2001); “International Guidelines on HIV/AIDS and Human Rights” (1997), available at www.unaids.org/html/pub/Publications/IRC-pub02/JC905-Guideline6_en.pdf.

3 WHO/UNAIDS/UNODC “Substitution maintenance therapy in the management of opioid dependence and HIV/AIDS prevention” Position Paper (2004), available at www.who.int/entity/substance_abuse/publications/en/PositionPaper_flyer_English.pdf.

persons in the region, it is imperative to examine these notions, laws, conventions and programs, and assess whether harm reduction is a viable response for the SAARC region, in accordance with international law.

2 CONTEXTUALISING NATIONAL LEGISLATIONS: INTERNATIONAL NARCOTICS CONVENTIONS

National laws impact vulnerability of IDUs to HIV infection and affect the utilization of treatment modalities.⁴ These legal frameworks may allow or obstruct, at the policy and programmatic level, the design of effective interventions to reduce infection rates and treat affected persons. Some states have attributed strict domestic legislations to their desire to conform to the United Nations Narcotics Conventions.⁵ It is important to note that under the UN Conventions, penal sanctions are central for drug-related offences, and everything else (including treatment) is optional.⁶ Since the UN Conventions vest the power of implementation to the states, legal scrutiny should focus on domestic legislation and its enforcement.

Due to the dual factors of (1) the significance of national laws, and (2) the rapidly increasing seroprevalence among IDUs across the world,⁷ it is necessary to examine the legislation in

SAARC countries and their impact on the vulnerability of IDUs to HIV as well as on harm reduction programming. Before proceeding to this examination, a brief overview of the international and regional conventions is required to understand the context of national legislations.

2.1 Applicability of Conventions

There are two types of State systems with regards to international law: monist and dualist. The former refers to a system wherein a country automatically meets its obligations under international conventions or treaties on ratification or accession to the international convention or treaty, and such obligations are directly enforceable under domestic law; the latter conceptualizes the international and domestic realms as separate and distinct, requiring a country to implement its obligations from the international realm by enacting domestic legislation.

In the SAARC region, Bangladesh, India, Pakistan and Sri Lanka are dualist systems. Nepal is a monist system. Initial research suggests that Bhutan has a dualist system.

2.2 Institution of a Prohibitionist Regime

A strict prohibitionist regime towards control of narcotics and psychotropic drugs epitomized international responses to drugs during the early part of the 20th century.⁸ The 1909 gathering of governments primarily sought to bring opium production within the purview of international control.⁹ Subsequent international agreements

4 See Malinowska-Sempruch, Hoover and Alexandrova "Unintended Consequences: Drug Policies Fuel the Epidemic in Russia and the Ukraine" International Harm Reduction Development (Open Society Institute, 2003).

5 Single Convention on Narcotic Drugs, 1961; Convention on Psychotropic Substances, 1971; United Nations Convention Against Illicit Traffic in Narcotic Drugs and Psychotropic Substances, 1988. See also Human Rights Watch "Not Enough Graves: The War on Drugs, HIV/AIDS and Violations of Human Rights in Thailand" Vol. 16 No. 8 (2004), available at <http://hrw.org/campaigns/aids/2004/thai.htm>.

6 See Gruskin, Plafker and Smith-Estelle "Understanding and Responding to Youth Substance Use: The Contribution of a Health and Human Rights Framework" in American Journal of Public Health Vol.91, No.12 (December 2001).

7 Gostin, Kirby and Gostin Complacency, Injustice and Unfulfilled Expectations: The AIDS Pandemic (University of North Carolina Press, 2004).

8 These agreements include the International Opium Convention 1912, the Agreement Concerning the Manufacture of Internal Trade In and Use of Prepared Opium 1925, the International Opium Convention 1925, the Convention Related to Dangerous Drugs ("Second Geneva Convention"), 1925, the Convention for Limiting the Manufacture and Regulating the Distribution of Narcotic Drugs 1931, the Agreement for the Control of Opium Smoking in the Far East 1931, the Convention for the Suppression of the Illicit Traffic of Dangerous Drugs 1936, and the Paris Protocol 1948.

9 See International Narcotics Control Board, press release, http://www.incb.org/e/press/1998/e_bn_01.htm.

attempted to limit and regulate opium and other narcotics.¹⁰

From 1961–1988, the older approaches to controlling drugs were consolidated, and three consecutive international drug conventions were ratified and acceded to by many countries. Under international law, countries that ratified these conventions are expected to incorporate the provisions into domestic laws.¹¹ The position in the earlier conventions was not modified after the advent of HIV/AIDS.

(a) 1961 and 1971 Narcotics Conventions

The Single Convention on Narcotic Drugs, 1961, heralded a new era of drug control, and the creation of an International Narcotics Control Board (INCB) to implement the Convention. This Convention, whose successors would follow suit, proscribed the use, possession and distribution of narcotics and psychotropic drugs.¹² The only exception is for "scientific or medical use" which is left undefined.¹³ Examples of the drugs included in the Schedule to this Convention include morphine, heroin and methadone.¹⁴ The Convention on Psychotropic Substances, 1971, expanded the list of proscribed drugs to include, for example, methamphetamines. These conventions reflected an international community's beliefs on drug control before the advent of the HIV/AIDS epidemic.

(b) 1988 Narcotics Convention

In the early 1980's, HIV/AIDS was identified as threatening vulnerable populations, including IDUs. It took half a decade for most political and scientific establishments to admit that a public health problem existed for these groups, and to further acknowledge that the boundaries of the epidemic extended beyond traditionally

marginalized groups, into the general population. Education in harm reduction behaviors increased, but an apathetic and bureaucratic approach continued to characterize the response to HIV/AIDS through the 1980s.

The dominant focus for dealing with drugs continued to be one of criminal justice instead of public health. In simple terms, a view prevailed that drug use was a moral wrong giving rise to criminal and moral culpability, overshadowing the notion that drug dependency is a medical condition requiring prevention and treatment.¹⁵ Thus, in 1988 when HIV/AIDS had firmly secured its place in the public consciousness, an international response to drugs still remained prohibitionist in its approach, neglecting harm reduction in favour of its "war on drugs". Although HIV/AIDS was recognized as an epidemic, injecting drug use was not yet a globally pervasive problem: that explosion happened only after 1988.¹⁶

The United Nations Convention Against Illicit Traffic in Narcotic Drugs and Psychotropic Substances follows the approach of its predecessors, focusing largely on international cooperation in targeting drug trafficking and eliminating the production, distribution, consumption and possession of narcotics.¹⁷ However, the 1988 Convention moved to an even stricter approach in dealing with drug-related activity.¹⁸ It urged that with respect to the possession of illegal drugs, countries "adopt such measures as may be *necessary*"¹⁹ to establish as criminal offences under its domestic law, when committed intentionally."²⁰ The provision enables national governments to create severe criminal penalties for mere possession, not just trafficking of drugs. Labelling injecting drug users as criminal

10 Ibid.

11 See Malinowska-Sempruch above n4.

12 Articles 2(5) and 4(c).

13 Article 4 (c).

14 See Malinowska-Sempruch above n4.

15 See Gostin above n7.

16 Malinowska-Sempruch above n4. See also Nadelmann "Commonsense Drug Policy" in *Foreign Affairs* Vol. 77, No. 1 (Jan/Feb 1998).

17 Article 3(1).

18 The United Nations Convention Against Illicit Traffic in Narcotic Drugs and Psychotropic Substances, 1988.

19 Emphasis added.

20 Article 3(1).

exacerbates vulnerability and fuels the HIV/AIDS epidemic by preventing them from accessing social and health services.²¹

2.3 Specific Provisions of the 1961, 1972 and 1988 Conventions Relevant to Harm Reduction

Supply, distribution, the proscription of personal consumption/use/possession, treatment and harm reduction are accorded differential status in the conventions:

- (a) **Supply and Distribution:** Distribution of illicit drugs is proscribed by the 1961, 1971 and 1988 Conventions. An exception is carved out in the 1961 Convention, mandating "medical prescriptions for the supply or dispensation of drugs to individuals". The 1971 Convention requires that distribution of specified drugs be under "a special license or prior authorization", and that such activities are closely supervised. These provisions allow the conventional interpretations of supply and distribution to be exempted in cases where drugs are required for medical purposes.
- (b) **Personal Consumption, Use and Possession:** In the 1961 Convention, the proscription of possession is found in articles 33 and 36(1). Article 3(2) of the 1988 Convention calls for Member states to "adopt such measures as may be necessary to establish as a criminal offence under its domestic law, when committed intentionally, the possession, purchase, or cultivation of narcotic drugs or psychotropic substances for personal consumption."

However, no distinction is made between possession for personal and commercial use (trafficking). Some governments recognise that this conflation fails to distinguish between mere users and traffickers, and

therefore exacerbates vulnerability of the former. They therefore adopted alternative measures of criminalisation within the flexibility provided by the international conventions. It is important to note that in South Asia, drug use has been accepted as a traditional part of socio-cultural practices.

- (c) **Treatment:** According to Article 36(1)(b) of the 1961 Convention, Member states "may provide, either as an alternative to conviction or punishment or in addition to conviction or punishment, that such abusers shall undergo measures of treatment". This provision is echoed in Article 22(1)(b) of the 1971 Convention and Article 3(4)(b) of the 1988 Convention. Furthermore, substances that are otherwise prohibited may be supplied or dispensed for use by a medical prescription, subject to the use being restricted to scientific or therapeutic functions, and in accordance with sound medical practice and subject to regulation.²²

In addition, Article 38 of the 1961 Convention and Article 20 of the 1971 Convention mandate that States give "special attention to and take all practicable measures for the early identification, treatment, education, after-care" of drug users. The Conventions also require States to promote the training of personnel for treatment. These requirements reflect an understanding that a comprehensive strategy should include efforts toward treatment and not mere criminalisation.

Treatment in the context of drug control is generally understood to mean detoxification and de-addiction. It remains to be seen whether other measures of harm reduction can be included in the rubric of treatment.

- (d) **Harm Reduction:** Article 38 of the 1961 Convention and Article 20 of the 1971

21 See Malinowska-Sempruch above n4.

22 Article 9, Convention on Psychotropic Substances 1971.

Convention do not explicitly include harm reduction strategies within the purview of treatment, though arguably these provisions could encompass harm reduction. Additionally, Article 4(c) of the 1961 Convention limits the possession and use of drugs to "scientific and medical purposes". This phrase is not elaborated but could feasibly include some harm reduction programs, including drug substitution methods such as methadone/buprenorphine substitution. Such a conclusion is amply supported by the international medical-scientific community's acceptance of drug substitution and other forms of harm reduction as medically and scientifically valid. The WHO/UNODC/UNAIDS Position Paper on substitution maintenance therapy states:

*"Opioid dependence is not just a heavy use of opioids, but a complex health condition that has social, psychological and biological determinants and consequences . . . it is not a weakness of character or will . . . the prescription for substitution therapy and administration of opioid agonists to persons with opioid dependence – in the framework of recognized medical practice approved by competent authorities – is in line with the 1961 and 1971 Conventions on narcotic drugs and psychotropic substances."*²³

However, it is an open question whether needle and syringe exchange programs would be included within the provision "scientific and medical purposes".

2.4 1998 UNGASS Declaration: Drug Demand Reduction

The United Nations General Assembly (UNGASS) held a Special Session on Drugs in 1998. At the time, an ongoing debate existed around

prohibition of drug laws and the effectiveness of the "war on drugs". In the debate, the three alternatives to prohibitive approaches included the legalization of drugs, the decriminalization of drugs, and the depenalization of drugs.

The Special Session resulted in the Declaration on the Guiding Principles of Drug Demand Reduction, a document that refrained from commenting on these alternatives to criminalisation. As a result, the Declaration served to reaffirm the principles set out in the narcotics conventions, and failed to give an adequate response to the growing issues around the spread of HIV.²⁴

However, the Declaration made mention of demand reduction policies being used to "reduce the adverse consequences of drug abuse". Furthermore, the Action Plan to supplement the Declaration stated that Member States would offer "the full spectrum of services, reducing the adverse health and social consequences of drug abuse". Such services could include efforts to promote harm reduction.²⁵

Simultaneously, Member States were being compelled to comply with the Conventions and Resolutions from the 1998 UNGASS on Drug Demand Reduction, which oblige States to achieve "significant and measurable results" in decreasing illicit drug consumption by 50%.²⁶ Such a goal focusing on the reduction of consumption renders governments unable or unwilling to recognize HIV vulnerability as a key concern, and/or incorporate harm reduction in domestic policies and programs.

Due to the unprecedented growth of HIV/AIDS, it is important that the international community

24 United Nations Declaration on the Guiding Principles of Drug Demand Reduction (1998).

25 Elliot, Kerr, Csete and Wood "Regime Change?: Drug Control, Users' Human Rights and Harm Reduction in the Age of AIDS", Draft Background Paper for Human Rights at the Margins: HIV/AIDS, Prisoners, Drug Users, and Law (Canadian HIV/AIDS Legal Network, 2004).

26 See Malinowska-Sempruch above n4 at 6.

recognizes that harm reduction approaches are an essential element in an overall comprehensive package of services for drug users.

3. INTERNATIONAL BODIES²⁷

Recognition by the UN bodies responsible for enforcing the Conventions of linkages between HIV and drug use, as well as support for harm reduction, has been limited.

3.1 Commission on Narcotic Drugs (CND)

The UN Commission on Narcotic Drugs is the chief policymaking body of the UN for international drug control and it oversees the policymaking of the UN Drug Control Programme (UNDCP). The CND is vested with the authority to propose amendments to existing drug control treaties or advance new drug control treaties or declarations. One structural/procedural obstacle to harm reduction in international legal instruments is the fact that any member of the CND may block a resolution.

In CND Res. 45/1,²⁸ the linkages between HIV and drug use are recognized, with emphasis placed on the need for sterile injecting equipment and drug therapy as part of effective HIV prevention, care and treatment. In the same resolution, Member States are encouraged to bear in mind HIV transmission routes when considering measures to reduce or eliminate the sharing of non-sterile injecting equipment.²⁹ Although this document is not binding, it suggests a potential paradigm shift within CND policies.

²⁷ This section is largely derived from Elliot above n25.

²⁸ CND Res. 45/1, "Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome in the Context of Drug Abuse" (15 Mar 2002), available at www.unodc.org/unodc/en/resolution_2002-03-15_1.html

²⁹ CND Res. 45/1 above n28.

3.2 United Nations Drug Control Programme (UNDCP)/Office of Drugs and Crime (UNODC)

The United Nations Office on Drugs and Crime (formerly the Office for Drug Control and Crime Prevention) was set up in 1997, combining the United Nations Centre for International Crime Prevention and the United Nations International Drug Control Programme. It was established by the Secretary-General of the United Nations to enable the Organization to focus and enhance its capacity to address the interrelated issues of drug control, crime prevention and international terrorism in all its forms. The mandate of the Office derives from several conventions and General Assembly resolutions, and the Office's technical cooperation programme aims to help improve the capacity of Governments to execute those international commitments.

UNODC has taken steps to link work on drugs with HIV. It is now a co-sponsor of UNAIDS and has established an internal HIV/AIDS Unit. Furthermore, in an Asia region report, UNODC prescribes that countries ensure drug and HIV legislation complement one another, focusing on preventing the spread of HIV amongst IDUs. In this report and in an internal memorandum to the International Narcotics Control Board, UNODC has stated that harm reduction modalities do not necessarily conflict with the UN Narcotics Conventions, and if there is a conflict, the Conventions may need to be reconsidered.

3.3 International Narcotics Control Board (INCB)

Compliance with the UN drug conventions is monitored by the INCB, an independent and quasi-judicial body with no authority to provide legally binding interpretations of the Conventions. The INCB has historically focused more on the implementation of the law enforcement aspects of the Conventions, than the implementation of drug treatment programs.

4. OTHER RELEVANT INSTRUMENTS

4.1 Regional Framework: The SAARC Convention on Drugs

"The SAARC Convention on Narcotic Drugs and Psychotropic Substances" follows the spirit of the UN Conventions and does not envision treatment as a primary focus. The relevant provision states that in addition to conviction or punishment, Member States may provide the offender with "treatment, education, after-care, rehabilitation or social re-integration."³⁰

It also states that "in appropriate cases of a minor nature, the Member States may provide, as alternatives to conviction and punishment, measures such as education, rehabilitation or social re-integration, as well as, when the offender is a drug abuser, treatment and aftercare."³¹ The concept of harm reduction is not explicitly articulated in this section and needs to be clearly defined. The SAARC Convention exempts "scientific or medical use" from its proscription of possession. An important divergence from the international Conventions is the absence of treatment as a requisite component of drug prevention in the absence of conviction or punishment.

The SAARC Convention recommends establishing as domestic offences the possession or purchase of narcotic drugs or psychotropic substances for the purposes of production, manufacture, sale, and other activities.³² Furthermore, the Convention recommends that Member States establish as criminal offences the possession, purchase or cultivation of narcotic drugs or psychotropic substances for personal consumption contrary to the provisions of the 1961 and 1971 Conventions.³³

30 Article 4(2).

31 Article 4(3).

32 Article 3(1)(c).

33 Article 2.

4.2 International Human Rights Instruments

The international and regional conventions exist in the context of a right to health, articulated in various legal instruments. The international human rights paradigm is a tool used to assess the legal and other responses to health, as well as the determinants of health.

The right to health was first articulated in the World Health Organization's (WHO) Constitution in 1946, stating that all persons are entitled to the highest attainable standard of health. The United Nations adopted the Universal Declaration of Human Rights (UDHR) in 1948, and various documents followed in its footsteps, including but not limited to the International Covenant on Economic, Social and Cultural Rights (ICESCR) and the International Covenant on Civil and Political Rights (ICCPR). The right to health was comprehensively laid out in Article 12 of the ICESCR, and the Committee on Economic, Social and Cultural Rights has adopted General Comment 14 on the parameters of right to health.

The right to treatment is a well-established component of the right to health.³⁴ The interpretations of the international Narcotics Conventions, and domestic laws enacted under the Conventions, should be in consonance with the principles of these international human rights instruments. The Conventions and domestic laws ought not to impede the right to health and treatment.

4.3 International HIV/AIDS Treaties

The right to health and treatment has been integrated into international documents on HIV/AIDS.³⁵ The Declaration of Commitment on HIV/AIDS harmonizes the apparent conflicts

34 Quoted in WHO "25 Questions and Answers on Health and Human Rights" Health and Human Rights Publication Series Issue No.1 (July 2002).

35 Above n2.

between the Narcotics Conventions and the realities of IDUs and HIV/AIDS. As mentioned earlier, countries interpreting the international Narcotics Conventions without recognizing the right to treatment, recognized under the 1961 and 1971 conventions, will not employ optimal HIV prevention strategies.

The UNGASS Declaration seeks to:

*"ensure... that a wide range of prevention programs . . . aimed at reducing risk-taking behavior and encouraging responsible sexual behavior, including abstinence and fidelity; expanded access to essential commodities, including male and female condoms and sterile injecting equipment; harm - reduction efforts related to drug use; expanded access to voluntary and confidential counselling and testing ; safe blood supplies; and early and effective treatment of sexually transmittable infections."*³⁶

The Declaration of Commitment also notes the necessity to develop strategies to reduce stigma and protect the health of groups vulnerable to and having high rates of HIV, such as those using drugs.³⁷ Additionally, the Declaration makes mention of the fact that negative legal factors are impeding prevention and treatment efforts, and highlights that availability and access to condoms and sterile-injecting equipment are essential for HIV/AIDS programs to work.³⁸

The International Guidelines on HIV/AIDS and Human Rights state:

"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:

- ◆ The authorization or legalization and promotion of needle and syringe exchange programs;
- ◆ The repeal of laws criminalizing the possession, distribution and dispensing of needles and syringes."³⁹

5. CONCLUSION

In the context of the HIV/AIDS epidemic, SAARC countries may find it appropriate to utilize key provisions of the 1961 and 1971 international Narcotics Conventions pertaining to treatment. As noted above, the Declaration of Commitment on HIV/AIDS and International Guidelines on HIV/AIDS and Human Rights demonstrate how countries may respond to the epidemic by promoting harm reduction for IDUs. Such interventions would be in consonance with provisions of the international Narcotics Conventions that specifically provide for treatment and other types of support. Though classically conventions and resolutions do not explicitly accommodate harm reduction, it is evident through the WHO/UNODC/UNAIDS report and other actions by international bodies that harm reduction needs to be an essential component of preventing the spread of the HIV/AIDS epidemic. Country responses also demonstrate that harm reduction is a viable and contextually appropriate response to decreasing IDU related HIV rates in the SAARC region.

³⁶ Declaration of Commitment on HIV/AIDS, above n2, emphasis added.

³⁷ Declaration of Commitment above n2.

³⁸ Declaration of Commitment above n2.

³⁹ OHCHR/UNAIDS "HIV/AIDS and Human Rights: International Guidelines" (Geneva, 1998) at para 10.

III. COUNTRY ANALYSIS – (A) BANGLADESH

1. DRUG USE AND HIV/AIDS: RISKS AND VULNERABILITIES

1.1. Drug Use

Like other countries in the SAARC region, Bangladesh has had a history of culturally sanctioned drug use, particularly cannabis and opium consumption. While cannabis use was widespread, it was not perceived to be a problem of abuse. In 1957, efforts were made to control opium by restricting its use to registered users who were supplied opium through licensed vendors by introducing the Opium Sales Rules 1957.¹ This system was discontinued in 1984, and in 1987 cannabis production was banned.² Vending of cannabis was banned in 1989³ in accordance with international obligations for narcotics control. Heroin addiction was reported during the mid to late 1980s⁴ largely among the lower socio-economic sections of society.⁵ Ingesting, inhalation and smoking were the common modes of taking drugs. In the mid-nineties, intensification of enforcement led to a reduction in heroin supplies resulting in an escalation of the street price of brown

sugar. Consequently, drug users turned to cheaper pharmaceutical alternatives such as Buprenorphine (tidigesic) and phensidyl, which were brought in from across the border. A National Assessment of Situation and Responses to Opioid/Opiate use in Bangladesh (NASROB) conducted in 2001 found the drug problem to be growing in the country.⁶

1.2 Injecting Drug Use (IDU)

Injecting drug use was first reported in the early 1990s and secondary data suggests an increase in the number of IDU in the recent past.⁷ A situational assessment conducted in 2001 found drug injecting in 19 of 24 districts surveyed.⁸ Dhaka, Rajshahi and Chapai Nawabganj record the highest number of drug dependent users who inject⁹ within a national estimate of 20,000 IDU.¹⁰ Commonly injected drugs include Buprenorphine, pethidine and mixtures of diazepam, promethazine hydrochloride and chlorpheniramine.¹¹

Risky injection and sexual practices among IDUs, including needle and syringe sharing, multiple sexual partners and unprotected sex, have been identified as factors underlying the

1 Centre for Harm Reduction "Revisiting 'The Hidden epidemic'– a Situation Assessment of Drug Use in Asia in the Context of HIV/AIDS", available at <http://www.chr.asn.au/freestyler/gui/files/bangladesh>.

2 Ibid

3 Md. Hamidul Haque, "Supply Reduction Approach to Drug Problem: Bangladesh scenario" in *Drugs: Treatment Works*, International Day Against Drug Abuse and Illicit Trafficking (Department of Narcotics Control, Ministry of Home Affairs, Government of Bangladesh, 26 June 2004).

4 South Asia Drug Demand Reduction Report, (UNDCP Regional Office for South Asia, New Delhi, India revised reprint, 2000) at 8.

5 "Revisiting 'The Hidden epidemic'" above n1.

6 FHI, CARE, HASAB "What will happen to us...?" National Assessment of Situation and Responses to Opioid/opiate use in Bangladesh (NASROB) (June 2002; reprinted August 2002).

7 Revisiting 'The Hidden epidemic' above n1.

8 NASROB above n6.

9 UNAIDS/AHRN/UNODC "Preventing HIV/AIDS among drug users: Case studies from Asia", Regional Task Force on Drug Use and HIV Vulnerability (2003) at 36, available at www.unaids.org/html/pub/Publications/IRC-pub03/AsiaDrugUsers_en_pdf.pdf.

10 "20,000 intravenous drug users in Bangladesh", *The Daily Star*, Bangladesh (October 14, 2004), posting on sea-aids@eforums.healthdev.org.

11 "Revisiting 'The Hidden epidemic'" above n2.

rapid spread of HIV/AIDS among IDUs and their partners.¹² Assessments conducted after the introduction of IDU interventions have found reduction in needle/syringe sharing among IDUs within coverage of harm reduction projects.¹³ However, no significant change was recorded in sexual practices of IDUs in project sites. Condom usage with sex workers remained low, reflecting the general pattern of poor condom usage in Bangladesh.¹⁴

The above risk factors are reflected in national seroprevalence trends as well. HIV prevalence among IDUs has seen a steep rise; infection rate among intravenous drug users escalated from 1.7% in 2001 to 4% within a year.¹⁵ A fifth round second-generation surveillance shows 8.9% seroprevalence among IDUs in a particular area in Central Bangladesh.¹⁶

1.3 Other Vulnerabilities

(a) Sex workers

According to a World Bank estimate, there are around 36,000 sex workers in Bangladesh operating out of brothels as well as on streets;¹⁷ estimates by NGOs place this figure at 150,000.¹⁸

Floating sex workers are reported to be present in large numbers and some estimates indicate that many single female textile and garment workers may be supplementing their low wages by selling sex occasionally.¹⁹ Despite their considerable presence/numbers, sex workers are one of the most marginalized social groups in Bangladesh with minimal access to social and/or legal protection.

Bangladeshi sex workers report poor rates of condom use with clients.²⁰ An official from the National AIDS/STD Programme notes: "Almost everyone who buys sex in Bangladesh is having unprotected sex some of the time." Over 70% drug users and IDUs reported frequenting sex workers.²¹ Sex without condoms was frequent, pointing to the possibility of sexual transmission of HIV/AIDS in addition to the risk of transmission through contaminated injections.

(b) Men who have Sex with Men (MSM)

Men who have sex with men is another group recognized as vulnerable to HIV/AIDS, behaviorally as well as because of socio-economic and legal disempowerment. Same sex activity including sex with male/transgendered sex workers is reported among drug users. Condom use is infrequent. A study found over 90% drug users to be unaware of the risk of acquiring STD and HIV infection through sex with other males/hijras.²²

12 NASROB above n6.

13 NASROB above n6.

14 A document released by the Ministry of Health and Family Welfare (MOHFW) in 2002 noted with concern that condom use has not been common, let alone consistent in Bangladesh because of low levels of awareness and risk perception among those susceptible to HIV. See "HIV in Bangladesh: Is Time Running out?" Background document for the dissemination of the 4th Round of National HIV and Behavioural Surveillance, National AIDS/STD Programme, DGHS, MOHFW (Bangladesh, June 2003) at 18.

15 Azim "Injecting Drug users and the HIV/AIDS Epidemic in Bangladesh" in *Drugs: Treatment Works International Day Against Drug Abuse and Illicit Trafficking* (Department of Narcotics Control, Ministry of Home Affairs, Government of Bangladesh, 26 June 2004).

16 "Common Man is no longer safe: HIV/AIDS in Bangladesh" *The Daily Star* (18 September 2004), posting on sea-aids@eforums.healthdev.org.

17 World Bank "Bangladesh HIV/AIDS Update" (2002), available at file:///Server/sar/sa.nsf/8b211d2239d56913852567d7005d8e54/ba0cdbb55ccecf28785256a9b0056d414?

18 Noorani "Sex Workers in Bangladesh" (2000), available at http://bulpup.lib.unca.edu/library/exhibits/MotherJones/shehzad_noorani.html.

19 See WHO "Bangladesh Country Profile" in *HIV/AIDS in Asia and the Pacific Region* (2003), available at <http://www.wpro.who.int/publications.asp?loop=1 and lcode=H and id=403>.

20 A study showed that consistent condom use was between 2.4% and 6% in all commercial sex acts in the previous week. See Salim "Current status of HIV/AIDS in Bangladesh and response of the National AIDS/STD Programme" in *Drugs: Treatment Works, International Day Against Drug Abuse and Illicit Trafficking* (Department of Narcotics Control, Ministry of Home Affairs, Government of Bangladesh, 26 June 2004). The 4th Round of National HIV Serological and Behavioral Surveillance (2000) found that condom use among clients of sex workers was as low as 15%-35%.

21 NASROB above n6 at 37.

22 "Revisiting 'The Hidden epidemic'" above n1. See also NASROB above n6.

1.4 HIV/AIDS

Bangladesh is considered a low prevalence but highly susceptible country to the AIDS epidemic. Behavioural surveillance firmly establishes a 'high risk' context, characterized by:

- 1) large numbers of males buying sex
- 2) low condom use in sexual encounters with sex workers
- 3) low levels of knowledge about HIV and AIDS
- 4) low perception of personal risk among vulnerable populations²³

According to the 5th Round of HIV and Behavioural Surveillance Data launched in 2002, there were 465 HIV positive reported cases (estimated number is 700–19,000 or 7,500, NASP) in the country.²⁴ The WHO estimates this figure to be between 2500–153,000.²⁵ HIV prevalence among the general population was reported to be below 1%.

Besides evidencing behavioral patterns that enhance risk of HIV/AIDS, Bangladesh presents structural factors that contribute towards vulnerability and a rapid escalation of HIV infections namely poverty, lack of education, unemployment, inadequate access to healthcare, gender inequity and violence against women, migration and mobility of populations.

2. DRUG USE AND HIV/AIDS: LAW AND POLICY FRAMEWORK

2.1 Overview of the Legal Framework

Bangladesh was proclaimed a sovereign and independent Republic in 1971. Prior to 1947,

it was part of undivided and colonised India. From 1947 until 1971, it was a part of Pakistan, referred to as East Pakistan. The Constitution of the People's Republic of Bangladesh was adopted in 1972.

Bangladesh is a parliamentary democracy with an elected government. The formal head of State is the President, who acts on the advice of the Prime Minister, the de facto head of government, and the Cabinet.²⁶ Law making power is vested with the Parliament, known as the Jatiya Sangsad (National Assembly).²⁷ The Constitution provides for independent legislative, executive and judicial wings of State administration.

2.1.1 Constitution

The Constitution is the supreme law of the land and all other laws have to be consistent with the principles set forth in the same, otherwise they are rendered void.²⁸ The Constitution guarantees a set of fundamental rights that cannot be infringed by any other law.²⁹ These entitlements include the right to equality and non-discrimination, the right to life and liberty, right to protection of law and privacy, freedom of movement, assembly, association, speech, thought and conscience, religion, occupation and profession.³⁰ Fundamental rights also provide safeguards against criminal procedures of arrest, detention, prosecution, trial and conviction.³¹ These protections are, however, not available to persons under preventive detention.³² Further, the exercise and enjoyment of rights is subject to reasonable restrictions imposed by law in the interest of national security, public order, public health, morality and decency.

23 Family Health International "Country profile: Bangladesh", available at www.fhi.org.

24 Email Communication with Zakiur Rehman, Programme Officer –DU, FHI Bangladesh.

25 "20,000 intravenous drug users in Bangladesh" above n10.

26 Article 48, Constitution of Bangladesh.

27 Article 65, Constitution.

28 Article 7, Constitution.

29 Article 26, Constitution.

30 Articles 27, 28, 29, 31, 32, 36,37,38, 39, 40, 41 and 43, Constitution.

31 Articles 32, 33 and 35, Constitution.

32 Article 33 (3 (b)), Constitution.

2.1.2 Religious law

Islam is the State religion. Personal/religious law is applicable in the personal/private sphere i.e. in matters related to marriage, divorce, inheritance etc. Unlike some other Islamic countries where principles of the Shariat have been codified and applied in criminal jurisprudence, the Penal Code and Criminal Procedure Code in Bangladesh have not been informed by religious proscriptions.

2.1.3 Courts

The responsibility of ensuring fundamental freedoms and protection for all citizens is entrusted with the Supreme Court³³, which comprises the High Court and the Appellate Division. The High Court Division hears original cases and appeals from lower Courts. Under the Constitution, the High Court Division of the Supreme Court is vested with the duty to safeguard fundamental rights.³⁴ The Appellate division of the Supreme Court reviews appeals of judgment by the High Court Division. Pronouncements and rulings of the Appellate Court are binding on all other Courts.³⁵ Over the years, 'activist benches' in the higher judiciary of Bangladesh have received acclaim for their declarations on rights of marginalized groups, environment and social justice.

The lower judiciary comprises the civil and criminal Courts at the district level, conciliatory Courts in municipal areas and village Courts in rural areas. While Magistrates belong to the executive branch of the government, the District and Sessions Judges are from the judicial cadre.³⁶ The legal system is based on English common law.

33 Article 44, Constitution.

34 Article 102, Constitution.

35 See "World Law: Bangladesh", available at <http://jurist.law.pitt.edu/world/bangladesh.htm#government>.

36 Ibid.

2.1.4 Criminal Justice System

Criminal justice is founded on three key statutes namely – the Penal Code 1860, the Code of Criminal Procedure, 1898³⁷ and the Evidence Act, 1872. The Penal Code lays down substantive offences, the Criminal Code delineates procedures and the Evidence Act contains provisions for nature, manner and admissibility of evidence in criminal and civil cases.

Concerns have been expressed about the arbitrary application and abuse of certain provisions, namely, section 54 of the Criminal Procedure Code and the Special Powers Act, 1974³⁸ that allow preventive detention.³⁹ Section 54 of the Code of Criminal Procedure authorizes police officials to arrest, without a warrant, persons on the basis of a reasonable suspicion of criminal activity. The Special Powers Act allows the government to detain persons 'suspected of involvement in prejudicial acts', a term so widely interpreted by officials and the magistracy as to reportedly result in arbitrary use.⁴⁰ Several human rights organizations have strongly condemned the manner in which these laws are invoked against poor and marginalized sections of the population including groups vulnerable to HIV/AIDS⁴¹ and have urged the government to repeal the same or enact enforceable safeguards.⁴² Bangladeshi Courts too have come down heavily against the conduct of the police force.⁴³

37 Act V of 1898.

38 Act XIV of 1974.

39 Odhikar "Abuse of Section 54 of the Code of Criminal Procedure" (2001) available at http://www.odhikar.org/pub/Pub3_1.htm.

40 UNDP "The Legal Framework for Human Security: The search for Clarity and Credibility" in "Human Security in Bangladesh: In Search of Justice and Dignity" (2002), available at <http://www.un-bd.org/undp/info/hsr/index.htm>.

41 Human Rights Watch "Ravaging the Vulnerable: Abuses against persons at high risk of HIV infection in Bangladesh" Vol 15, No. 6 (August 2003).

42 See The Legal Framework for Human Security above n40. See also Amnesty International "Bangladesh: Urgent need for legal and other reforms to protect human rights", AI Index: ASA 13/012/2003 (May 2003) and Human Rights Watch above n41.

43 See BLAST v. Bangladesh 4 BLC 600, where the High Court division condemned police excesses and urged the authorities to frame a

2.2 Drug Use and HIV/AIDS Harm Reduction Law

2.2.1 General penal provisions

Aiding and instigating the commission of an offence is punishable⁴⁴ under the Penal Code as also criminal conspiracy.⁴⁵

Penal provisions prohibiting distribution of 'obscene' material⁴⁶ and commission of an 'obscene' act in public⁴⁷ may be attracted by harm reduction programs if the contents of HIV prevention material or street education activity like condom demonstration is deemed to be objectionable on moral grounds.

2.2.2 Sex work

The Suppression of Immoral Traffic Act, 1933, the substantive law on prostitution,⁴⁸ does not criminalise sexual transactions per se but prohibits brothel-keeping,⁴⁹ solicitation in streets and in public places.⁵⁰ Other punishable activities related to prostitution include living on earnings of a prostitute,⁵¹ procuring or inducing a female,⁵² importing or attempting to bring for hire⁵³ and detaining of females of any age.⁵⁴

Besides delineating offences, the Act also lays down procedures for rescue, removal, custody and restoration of minor girls involved in sex work.⁵⁵ The Act applies to female sex workers only.⁵⁶

The Vagrancy Act, 1950 is another statute that is applied to place sex workers, particularly those operating in streets, in vagrants' homes, ostensibly, to rehabilitate them. In 1999, the forcible eviction of brothel-based sex workers from Tanbazar and Nimtoli areas of Dhaka and their subsequent confinement in the Kashimpur Vagrant Home at Gazipur under the Vagrancy Act was challenged before the High Court Division of the Supreme Court. In an unprecedented judgment⁵⁷ delivered in March 2000, the Court declared that sex workers do not come squarely within the definition of vagrant⁵⁸ under the Act. Referring to a decision of the Supreme Court of India that read the right to livelihood within the meaning of fundamental right to life,⁵⁹ the Bangladeshi High Court held that sex workers enjoy the same rights as other citizens and their illegal eviction is tantamount to a violation of their right to life and livelihood. The Court went on to observe that though sex work is socially censured in Bangladesh, it is not illegal under the law of the land as the Suppression of Immoral Act does not prohibit consensual adult prostitution.

The Dhaka Metropolitan Police Ordinance, which prohibits soliciting in public for the purpose of prostitution and section 54 of the Criminal

Code of Conduct for the law enforcement agency in consonance with the Code of Conduct of Law Enforcing Agency adopted by the General Assembly of the United Nations by resolution 34/169 of 17th December 1979.

44 Section 107 defines abetment. Section 109 lays down punishment for abetment. See Part V, Bangladesh Penal Code.

45 Section 120 A defines criminal conspiracy to mean an agreement between two or more persons to do or cause to be done an illegal act or an act, which is not illegal by illegal means. Punishment for criminal conspiracy is contained in Section 120 B.

46 Section 292 prohibits sale, distribution, circulation, exhibition of obscene material, pamphlets, writing etc. Section 293 imposes a higher punishment if such objects are offered to young persons.

47 Section 294 makes acts done in public to the annoyance of others a punishable offence.

48 The Suppression of Immoral Traffic Act, 1933 (Bengal Act VI of 1933).

49 Section 4.

50 Section 7. Further, persons soliciting for prostitution can be arrested without a warrant under Sec 22 of the Act.

51 Section 8.

52 Section 9.

53 Section 10.

54 Section 11.

55 Sections 13, 14, 17, 18 and 19.

56 Section 3(4) defines a prostitute as "any female available for the purpose of prostitution".

57 BSEHR v. Govt. of Bangladesh and others 53 DLR (2001) 1. The appeal filed by the government against the order of the High Court Division of the Supreme Court of Bangladesh was rejected by the Appellate division in a judgment dated 8th August 2004 in Secretary Ministry of Home Affairs and ors v. BSEHR.

58 The Bengal Vagrancy Act, 1943 (Act VII of 1943) defines vagrant to mean a person

"found asking for alms in any public place in such condition or manner as makes it likely that such person exists by asking for alms but does not include a person collecting money or asking for food or gifts in a prescribe manner."

59 Olga Tellis vs Bombay Municipal Corporation AIR 1986 SC 180.

Procedure Code are other criminal provisions reportedly invoked against street sex workers.⁶⁰

2.2.3 Unnatural Offences/Sodomy

Section 377 of the Penal Code 1860 criminalizes "unnatural sexual offences" that include consensual anal and oral sex between males.⁶¹ This section, read with criminal conspiracy and abetment provisions in the Penal Code threatens sexual health promotion projects for MSM with closure and criminal liability.

2.2.4 Drug use

In furtherance of its international commitments, Bangladesh enacted the Narcotics Control Act, 1990.⁶² The Act aims to control Narcotic drugs and psychotropic substances and to provide measures for treatment and rehabilitation of drug users.⁶³

(a) Classification of prohibited substances

Narcotics drugs, psychotropic substances and precursor chemicals are included within the meaning of 'narcotics' under the Act.⁶⁴ The Schedule categorizes narcotics or prohibited substances into:⁶⁵

- ◆ A-Class, which includes Heroin, Cocaine, Opium, Cannabis resin, Pethidine, Morphine and Methadone

- ◆ B-Class, which includes Ganja, Herbal cannabis, Alcohol, Liquor, Cannabis plant, LSD, Barbiturates, and Amphetamine
- ◆ C-Class, which includes Sedatives, Tranquilizers like Diazepam, Triazolam, Stimulants and Depressant Medicines

Methadone, which is the most commonly prescribed treatment in oral substitution programs, is expressly prohibited as an A-Class drug.

(b) Offences and Penalties

The Act prohibits:

- ◆ Cultivation
- ◆ Production
- ◆ Carrying and transportation
- ◆ Import and export
- ◆ Supply
- ◆ Purchase and sale
- ◆ Possession
- ◆ Preservation and warehousing
- ◆ Exhibition and;
- ◆ Use

of narcotics except for producing approved medicines, treatment, industrial use or if it is necessary for conducting scientific research.⁶⁶ Use for industrial, medical and scientific purposes is permitted only under a license issued by the Director General of the Department of Narcotics Control (DNC) or by an officer authorized by him.⁶⁷

Besides narcotics, alcohol is also forbidden under the Act. While non-Muslims can drink after obtaining a permit, Muslims can consume alcohol only if it is medically indicated and certified by a physician as such.⁶⁸

60 Human Rights Watch above n41 at 28.

61 Section 377, Bangladesh Penal Code:

"Whoever voluntarily has carnal intercourse against the order of nature with any man, woman or animal, shall be punished with imprisonment for life or with imprisonment of either description for a term which may extend to ten years, and shall also be liable to fine."

62 Bangladesh is a signatory to all three drug related conventions namely – the 1961 Single Convention on Narcotic Drugs, as amended by the 1972 Protocol, the 1971 UN Convention on Psychotropic Substances and the 1988 Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances. At the regional level, it is a party to the 1990 SAARC Convention on Narcotic Drugs and Psychotropic Substances.

63 The Narcotics Control Act, 1990 (Act No. XX of 1990).

64 Section 2(l) defines narcotics to mean drugs and psychotropic substances or any other substance mentioned in the First Schedule.

65 Section 2(m) and First Schedule.

66 Section 9.

67 Section 11(1). Under section 12, licenses cannot be issued to persons convicted for moral turpitude, for offences under the Act or if a previously issued license or permit has been cancelled. A previously issued license/permit or pass can be cancelled for contravention of terms and conditions provided thereunder or if the grantee is convicted for a cognizable offence.

68 Section 10 and Second Schedule.

The quantum of punishment for offences listed in section 9, except cultivation, depends on the nature and the quantity of substance involved. Punishment is harshest for offences involving A-Class narcotics (ranging between 2 and 10 or 15 years imprisonment for lesser quantity and death sentence or life imprisonment for higher quantity in addition to fine). Offences related to B-Class narcotics attract comparatively lesser severe penalties (ranging between imprisonment for 6 months to 3 years for lower quantity in addition to fine), while for C-Class narcotics punishment is least severe (imprisonment of less than 1 year and fine TK 10, 000). Punishment is doubled for repeat offences.⁶⁹

While recreational use of narcotics is outlawed, the Act permits drug use if medically indicated. The system of medical prescription though is strictly regulated. It is mandatory for a physician prescribing narcotics classified as A or B by to obtain prior written approval of the Director General.⁷⁰ Use of Class C narcotics is controlled to the extent that only a physician can prescribe them.⁷¹ Further, even with prescription, narcotics can be purchased only once.⁷² Such rigid regulations and restrictions will have implications for drug substitution and maintenance programs, if the same are introduced.

The Act places drug consumption in the same league, as other offences of manufacture, sale and supply etc. Possession and use are separate offences and from the perspective of the user, imply the possible burden of facing a dual charge if arrested with illicit substances.

Possession of paraphernalia, such as needles, syringes and bleach, does not amount to an offence. Carrying needles and syringes may not directly bring IDUs in conflict with the law. Distribution of paraphernalia like needles and syringes is,

however, in contravention of the Act and may, in a case, amount to abetment of drug use. The statute punishes instigating, aiding and conspiring with a person for the commission of any offence with imprisonment between 3 and 15 years and with fine.⁷³ Hardly any NGO running needle syringe exchange programs for IDUs has been prosecuted under this section till date. Still, the ambiguity surrounding NSEPs poses questions for support, scale up and sustainability of such measures in a country where HIV prevalence among IDUs is rising and heroin smokers are switching to injection.⁷⁴

Oral drug substitution, though currently not in place, would be unlawful, unless read into the exception of medically prescribed narcotics treatment. While certain public health agencies have expressed support for introducing oral drug substitution as an HIV/AIDS prevention measure among IDUs, the DNC appears to favour measures for permanent elimination of drug use.⁷⁵

The Act makes a person who knowingly allows her/his premises including homestead, transport and equipment for commission of any offence liable for imprisonment for five years.⁷⁶ Owners and occupiers of premises that are used for needle exchange operations and as drop in centres for IDUs can be held liable for letting out premises for harm reduction interventions.

(c) Powers and procedures

All offences under the Act are cognizable,⁷⁷ enabling the police and narcotics control officials to arrest without a warrant. Powers of entry, inspection,⁷⁸ search of premises and seizure of narcotics and/or equipment/apparatus, and arrest are vested with the Director General of the DNC and with the

69 Section 19.

70 Section 13(1).

71 Section 13 (2).

72 Section 13 (3).

73 Section 25.

74 NASROB above n6.

75 CARE "Seminar on Harm Reduction Approach in HIV Prevention Program in Bangladesh: Seminar Report" (Bangladesh, March 2004).

76 Section 21, Narcotics Control Act, 1990.

77 Section 31.

78 Section 32.

Bangladesh Rifles.⁷⁹ Premises that can be searched include places accessible to public.⁸⁰

In addition to regulatory and policing authority, the Director General has been conferred with magisterial powers to issue warrants for arrest of person suspected of committing offence.⁸¹

Enforcement officials can exercise powers not only when an offence is committed but also on reasonable suspicion that an offence has been, is being or is likely to be committed.⁸² A person suspected of concealing narcotics can be compelled to undergo body search and examination, including urine testing.⁸³ A person likely to commit an offence in a public place can be searched, detained and arrested.⁸⁴ Although the Act grants wide, discretionary powers to officials, the same have been brought under safeguard by a provision that imposes criminal liability on officers conducting illegal searches and for harassing or seizing property belonging to any person.⁸⁵

Extensive powers vested with enforcement officials under the Act render harm reduction spaces open to intrusion and disruption. Drop-in centres, project sites for IDU can be raided, NSEP equipment can be seized and client records can be confiscated. The absence of formal support/endorsement/protection from narcotics enforcement bodies would make it difficult for NGOs to reach out to and work with criminalized populations such as drug users on a sustained basis.

(d) Statutory structure for implementation

The Act designates the National Narcotics Control Board (NNCB),⁸⁶ a high-powered interministerial

body chaired by the Minister of Home Affairs⁸⁷ and having representation from all ministries including Health and Family Welfare, Education, Law and Justice, Home and Foreign Affairs, as the apex policy-making body. The board elicits participation of nominated members from civil society including a social worker, journalist and a physician/psychiatrist, who hold office for a period of two years.⁸⁸

The roles and responsibilities of the NNCB include framing policies for prevention of drug abuse, treatment and rehabilitation of drug users and for manufacture, supply and use of narcotics.⁸⁹ The NNCB is authorized to constitute a National Narcotics Control Board Fund to generate resources for awareness, prevention, treatment and rehabilitation interventions.⁹⁰ Besides allocation of resources from the government, the Fund may also receive grants from foreign donors and aid agencies.⁹¹ The Fund has received some foreign contribution. After 2000, sale proceeds from confiscated drugs and forfeited assets have been deposited to the Fund.⁹²

The Department of Narcotics Control (DNC) under Ministry of Home Affairs, Government of Bangladesh is the principal agency for implementation of policies.⁹³ The Director General of the Department is the chief official responsible for the execution and implementation of narcotics control measures under the Act. S/he is the Member Secretary of the NNCB and acts as the executive agency of the Board.⁹⁴

The DNC has four operational wings namely: (1) Administration, Finance and Common Service, (2) Operation, Traffic and Intelligence, (3) Preventive Education, Research and Publication and

79 Section 36.
80 Section 41.
81 Section 40.
82 Section 36.
83 Section 37.
84 Section 41.
85 Section 24.
86 Section 4.

87 Md. Hamidul Haque above n3.
88 Section 4, Narcotics Control Act.
89 Section 5.
90 Section 7.
91 Section 7.
92 Communication with Zakiur Rehman above n24
93 Section 8, The Narcotics Control Act.
94 See Md. Hamidul Haque above n3.

(4) Treatment and Rehabilitation.⁹⁵ In 2000, the DNC established its own Drug Testing Laboratory and has been coordinating anti-narcotics activities at the district level through District Drug Control Committees.⁹⁶ In addition to the DNC, other agencies entrusted with the task of enforcement include the Police, the Bangladesh Rifles (BDR), the Customs and the Coast Guard.⁹⁷

(e) *Treatment and rehabilitation*

The Act defines an addict as a person physically or mentally dependent on narcotics or a person who habitually takes narcotics.⁹⁸

According to amendments to the Act in 2000, drug users facing trial for the offence of drug consumption can opt for treatment in lieu of a sentence of imprisonment.⁹⁹

For treatment of drug dependence, the Government may establish Narcotics Addiction Treatment Centres and declare government hospitals or health centres, including jail hospitals, as narcotics treatment centres under the Act.¹⁰⁰ Presently, there is only one central drug addiction treatment centre in Dhaka, with forty beds¹⁰¹ and three other regional treatment centres in Chittagong, Rajshahi and Khulna with five beds each. The central treatment centre is being expanded to 100 beds for detoxification and 150 beds for rehabilitation.¹⁰² None of the jails have specific programs for drug users in place.¹⁰³ The Act was modified in 2000 to authorize NGOs to operate detoxification and rehabilitation programs.¹⁰⁴ NGOs and private

practitioners run over 100-detoxification facilities throughout the country.

Notwithstanding the dearth of medical facilities, the Act mandates compulsory treatment of addicts.¹⁰⁵ The Director General, or an officer authorized by him, has the power to direct a drug user or a person who remains in a state that is 'abnormal' on account of narcotic use to submit himself/herself to treatment. The procedure for compelling drug users to show up for treatment is fairly detailed, and the Director General has the authority to issue legal notice to the addict or her/his custodian/guardian. Non-compliance with notice triggers a judicial procedure and the Magistrate can order the addict to visit a physician or treatment centre. The Act allows application of force to send an addict for treatment if s/he fails to attend Court despite notices and judicial orders.¹⁰⁶ The cost of treatment is to be borne by the government.¹⁰⁷

Besides compulsory detoxification, the Act also requires mandatory reporting of addicts by family members and physicians treating drug users for other illnesses to the Director General,¹⁰⁸ who is required to maintain a district-wise list of drug dependent users to facilitate treatment.¹⁰⁹ Further, drug users can, on their own or through their guardian/physician, seek inclusion in such list.¹¹⁰ According to anecdotal information, reporting of drug users is not undertaken despite the statutory provision for the same.¹¹¹

However, ultimately the above provisions are inconsequential because public facilities for treatment and effective rehabilitation of users are non-existent. Practically, the government cannot implement mandatory detoxification and treatment of users. As a drug treatment

95 Md. Hamidul Haque above n3.

96 Md. Hamidul Haque above n3.

97 Md. Hamidul Haque above n3.

98 Section 2 (n), Narcotics Control Act.

99 Communication with Zakiur Rehman above n24.

100 Section 15, Narcotics Control Act.

101 See Mallick "Meeting the treatment and Rehabilitation needs of Drug users in Bangladesh" in *Drugs: Treatment Works, International Day Against Drug Abuse and Illicit Trafficking* (Department of Narcotics Control, Ministry of Home Affairs, Government of Bangladesh, 26 June 2004).

102 Communication with Zakiur Rehman above n24.

103 NASROB above n6 at 10.

104 Communication with Zakiur Rehman above n24.

105 Section 16 Narcotics Control Act.

106 Section 16 (7).

107 Section 16 (8).

108 Section 17.

109 Section 48.

110 Section 48.

111 Communication with Dr. Munir Ahmed, CARE Bangladesh

intervention strategy, a mandatory approach compelling users to undergo detoxification has few supporters especially when experience shows that more than anything else, it is the addict's willingness to 'come clean' that enables successful recovery and lessens chances of relapse.

2.3 Policy Framework for Drug Use and HIV/AIDS

2.3.1 Drug demand reduction

The Department of Narcotics Control is entrusted with the task of policy-making for drug abuse prevention, education, treatment, rehabilitation and after care of users. The documents guiding demand reduction activities include the Five Year Master Plan for Drug Abuse, Prevention and Control, 1991, National Drug Demand Strategy, 1995, the Five-Year Strategic Plan, 1997¹¹² and the most recent National Strategic Plan 2004–2010.

The overall goal articulated in the National Master Plan, 1991 is to mitigate the impact of drugs on individuals, families and communities, while the immediate objective is to introduce preventive education and services for treatment and rehabilitation.¹¹³ The Master Plan document outlines the framework for demand reduction interventions, which have been two-fold: (1) for drug abuse prevention and education and (2) for treatment and rehabilitation of those already dependent on drugs.¹¹⁴

The Five Year Strategic Plan for drug abuse control adopted in 1997 identified specific goals for demand reduction and proposed strategies for prevention and treatment. Measures towards preventive action included development of media campaigns, training, work place interventions and restrictions on use of pharmaceutical products. Development of a client monitoring system,

involvement of NGOs and community, promotion of research and monitoring as well as undertaking harm minimization were spelt out as strategies for treatment and rehabilitation.¹¹⁵

The current National Strategic Plan 2004–2010 emphasizes the need to provide support and services to drug users as a priority.¹¹⁶

A review conducted in 1997 by the UNDCP, which offers technical and financial assistance to the programme, called for greater integration between prevention of drug addiction and treatment of dependents. Concerns about spread of infectious diseases like HIV/AIDS and hepatitis in the context of drug use – especially injecting drug use – were also noted.¹¹⁷

By and large, policy directives in the drug abuse sector remain abstinence-focused, although in the recent past DNC as well as police officials have not significantly hindered harm reduction measures, including NSEPs.¹¹⁸

2.3.2 HIV/AIDS

A formal institutional response to the HIV/AIDS epidemic was initiated by the government as early as 1985, when a National AIDS Committee (NAC) was formed as an advisory body for policy and strategy establishment. In addition to the NAC, a Technical Committee comprising of experts and a Coordination Committee consisting of coordinators for surveillance, counselling, and allied health services were set up by the end 1990.¹¹⁹ By mid-1996, the Bangladesh AIDS Prevention and Control Programme was launched, as a 'tripartite

112 South Asia Drug Demand Reduction Report above n4 at 93.

113 South Asia Drug Demand Reduction Report above n4 at 93.

114 South Asia Drug Demand Reduction Report above n4 at 94.

115 South Asia Drug Demand Reduction Report above n4 at 94.

116 Communication with Zakiur Rehman above n24.

117 Communication with Zakiur Rehman above n24.

118 Speeches by Mr. Kamaluddin Ahmed, Director General, DNC and Mr. Shahudul Haque, Inspector General of Police, reproduced in CARE "Seminar on Harm Reduction Approach in HIV Prevention Program in Bangladesh: Seminar Report" (Bangladesh, March 2004)

119 Sustainable Development Networking Programme "Chronology of HIV/AIDS Intervention in Bangladesh", available at http://www.sdnbd.org/sdi/international_day/aids/2001/history.htm.

coalition' between the Ministry of Health and Family Welfare (MOHFW), acting as the executive agency, the Directorate General of Health Services (DGHS) that is the implementing body and the NAC, taking on an advisory role.¹²⁰

The National Policy on HIV/AIDS and STD related issues was drafted by a multi-sectoral task force comprising of government and civil society experts and was formally adopted by the Government in 1997. The policy underscores the need for an 'integrationist approach' towards HIV prevention and control by recognizing the importance of an enabling and supportive legal and social environment.¹²¹ Human rights, gender, behaviour, and information, education and communication (IEC) have been identified as four cross-cutting priority themes.¹²² Mandatory testing and other practices that increase stigma are discouraged and the document lays down detailed guidelines for provision of counselling and confidential testing for HIV/AIDS after taking informed consent.¹²³

The document makes special reference to vulnerable groups such as sex workers and injecting drug users, endorsing interventions that 'empower' rather than impede rights.¹²⁴ However, no programs have been spelt out for MSM, another group that is susceptible to HIV/AIDS.¹²⁵ In the specific context of drug use, it recommends interventions that include outreach, needle and syringe exchange and cleaning, and STD treatment amidst other harm reduction measures. In addition to the national policy, the Strategic Plan of the National AIDS Programme that proposes operational measures for implementation

delineates peer education, condom distribution, substitution of injections with oral drugs, health education and counselling, support groups and recovery programs as other components of IDU projects.¹²⁶ While prioritizing harm reduction for IDUs, the strategic plan stresses the need for consistency between activities targeted at IDUs and the overall drug abuse prevention strategy.¹²⁷

3. DRUG USE AND HIV/AIDS HARM REDUCTION PRACTICES

3.1 Prevention

3.1.1 Drug Use

Overall, demand reduction programming, which is largely handled by the government with involvement of some NGOs, was found inadequate to deal with the magnitude of the problem. Drug use is still seen as criminal activity and not as a health concern.¹²⁸ A high proportion of users including IDUs and heroin smokers are reported to have been in jail, where therapeutic services are non-existent.¹²⁹ Thus far, demand reduction policies of the government have not critically looked at concerns of drug injecting and HIV epidemics and the DNC's programs are limited to awareness creation.

3.1.2 HIV/AIDS

(a) *Information education communication(IEC)/Behaviour Change Communication (BCC)*

The National Program focuses on behaviour change messages targeted at individuals

120 See DGHS, MOHFW, Government of Bangladesh "National Policy on HIV/AIDS and STD-related Issues" Part II (Final Draft, 1996). Hereinafter the National Policy.

121 National Policy.

122 Executive Summary, National Policy

123 See National Policy, Part III "Specific Guidelines on HIV Testing Policy and also Counselling of HIV/AIDS Patients and Confidentiality".

124 See National Policy, "Commercial Sex".

125 See National Policy, "HIV/AIDS/STD and Men". The document makes a only fleeting reference to male-to-male sex within the larger context of male sexual behaviour, possibly to avoid formal recognition of homosexuality in the country.

126 DGHS, MOHFW, GOB "Strategic Plan of The National AIDS Programme of Bangladesh 1997-2002", (Bangladesh AIDS Prevention and Control Programme, Primary Health Care and Disease Control, , July 2000) at 19. Hereinafter National Strategic Plan.

127 National Strategic Plan at 15.

128 Interviews with users and ex-users in Dhaka (October 2004, Country visit notes on file with the Unit).

129 NASROB above n6 at 42.

engaging in unsafe sexual practices such as sex workers and their clients, truck drivers, professional blood donors and young people. Messages on injection safety to prevent HIV/AIDS are disseminated by NASP through print and electric media.¹³⁰ Peer education, community messages and outreach are some of the strategies used to reach out to vulnerable groups. Typically, a BCC message emphasizes abstinence but does not exclude condom use altogether. Some NGOs such as CARE Bangladesh and Marie Stopes have reportedly developed specific material on safer injection and sexual practices for drug users.¹³¹ Reports available do not suggest condemnation or restriction of HIV/AIDS prevention messages on legal or religious/cultural grounds.

(b) Condom promotion

The Strategic Plan and the National AIDS Policy endorse condom promotion as the mainstay of HIV prevention programming. Social marketing and free distribution by NGOs are the main channels of supply.¹³² Condoms are also available at general stores and pharmacies. Religious restrictions or conservative political thought have reportedly not blocked condom supply and advertising.¹³³ Targeted intervention projects like CARE SHAKTI (Stopping HIV/AIDS through Knowledge and Training Initiative) distribute free condoms and supply them on demand. Condom provision is also a part of male sexual health programs that primarily reach gay men and transgendered or hijra sex workers.¹³⁴

The legislative framework does not oppose condom provision and promotion, except among men having sex with men.¹³⁵ Yet, police action

against peer educators, sex workers and sexual minorities is reported to be a hindering factor in promotion of safe sex among marginalized communities.¹³⁶ Even though the law may not directly pose a problem to condom distribution per se, the socio-legal context that IDUs, sex workers and MSM find themselves in is not conducive to instilling behaviour change at individual or community levels.

(c) Treatment for Sexually Transmitted Infections (STIs)

The National Programme recognizes the importance of providing confidential and client friendly treatment for STIs as a means of averting HIV transmission.¹³⁷ Intervention programs with sex workers, transport workers and IDUs offer on-site treatment for STIs. Assessment reports, however, indicate that the impact of interventions has been not so optimal since rates of sexually transmitted infections among IDUs¹³⁸ and sex workers remains high.¹³⁹ An earlier survey conducted on male sexual health in Dhaka showed that neither government nor NGO treatment and referral centres treated anal STIs, indicating exclusion of MSM from clinical services.¹⁴⁰ Male sexual health projects have been initiated since to provide STI treatment to MSM besides other HIV prevention services.¹⁴¹

(d) Needle Syringe Exchange Programme (NSEP)

At a policy level, the Health Ministry supports NSEPs among other harm reduction measures with IDUs. CARE Bangladesh, an international health and development aid agency, started the

130 Communication with Zakiur Rehman above n24.

131 Communication with Munir Ahmed above n145.

132 National Strategic Plan at 15.

133 Interview with NGO functionaries. (October 2004, Country visit notes on file with the Unit).

134 Bandhu Social Welfare Society is one NGO implementing such programs in nine cities with support from FHI and the Naz Foundation International Trust.

135 Abetment of crime of 'unnatural sexual offences' under section 377 of the Bangladesh Penal Code.

136 Human Rights Watch above n41.

137 Ibid at 19.

138 "Outreach In Dhaka" above n9 at 29.

139 NASRO above n6. See also, "HIV in Bangladesh: Is Time Running out?" above n14.

140 Shivananda Khan, "Sex, secrecy and shamefulness – developing a sexual health response to the needs of males who have sex with males in Dhaka, Bangladesh" (Naz Foundation International, 1997) at 26, available at www.nfi.net.

141 FHI Bangladesh Country Profile above n23.

first NSEP in 1998 in Dhaka under Project SHAKTI. The objective of the program is to provide a broad spectrum of health services to IDUs in order to reduce risk of transmission of HIV and other blood borne diseases, treat ailments related to drug use and establish an environment conducive to behaviour change.¹⁴² The main activities under the project are setting up of drop-in centres, offering services to IDUs through outreach, training of peer educators, advocacy and sensitization of police and the community.¹⁴³

Drop-in centres offer a safe space to IDUs, along with basic medical care including treatment for STIs, abscesses and other ailments. Clean needles and syringes are offered in exchange for used ones through outreach. Mostly, there is one-for-one exchange, with some exceptions. Returned syringes and needles are counted and destroyed in an incinerator. In addition to service provision, the SHAKTI project team also trains ex-users, pharmacists and drug peddlers on safe injecting practices in an effort to facilitate peer education. Sensitization of the community, particularly families of IDUs, local residents and police is also undertaken to pre-empt and mitigate resistance/complaints.

Project SHAKTI reaches over 3,000 IDUs in Dhaka alone. Over the years, the NSEP has been expanded and introduced in other districts such as Rajshahi and Chapai Nawabganj. In 2002, coverage was expanded to include other drug users, particularly heroin smokers, to address transition from and between injecting and other drug use.¹⁴⁴ Presently, CARE Bangladesh has programs in 23 districts.¹⁴⁵ Assessment studies point out that the intervention has been successful in reducing needle sharing among IDUs.¹⁴⁶

142 "Outreach In Dhaka" above n9 at 26.

143 Ibid

144 See CARE Bangladesh brochure on HIV Program.

145 Communication with Dr. Munir Ahmed above n145.

146 Surveillance data shows that IDUs in intervention sites share less than their counterparts in non-intervention sites. See Azim above n15. Interventions have also been effective in reducing the number of injection sharing partners. See NASROB above n6 at 9.

Police and enforcement activities pose formidable challenges to the CARE Bangladesh intervention. Project functionaries note that police harassment, raids and spot evictions compel street users to go underground, thereby making it difficult for service providers to reach them with education, clean needles and condoms.¹⁴⁷ There is considerable interface between street users and law enforcement: one survey shows that nearly 70% of users (heroin smokers and IDUs) have been in police lock up at least once.¹⁴⁸ Field workers also reportedly face obstruction in their outreach work from local police.¹⁴⁹ In this context, health officials have repeatedly urged greater interaction and co-operation between NGO staff and police department to ensure better functioning of the NSEP.¹⁵⁰

The Narcotics legislation criminalizes consumption of drugs. Supplying equipment like needles/syringes to IDUs that facilitate illicit drug use constitutes 'abetment'. Technically then, NSEPs are operating in contravention of the law. Till date, there are no reports of the Narcotics Control Act being invoked to stop such interventions. Some reports, however, suggest that the police apprehend outreach workers at NSEP sites although no case of abetment or any other offence under the Narcotics Control Act has been lodged.¹⁵¹

The DNC is aware of NSEPs and there is 'cautious acceptance' of harm reduction measures on the part of narcotics officials.¹⁵² Such acceptance

147 Bosu "Presentation on Drug Users Intervention HIV program of CARE Bangladesh" in CARE Bangladesh "Seminar Report on Harm Reduction Approach in HIV Prevention Program in Bangladesh" (March 2004).

148 NASROB above n6 at 42.

149 Interview with CARE Bangladesh outreach workers in Dhaka (October 2004, Country Visit Notes on file with the Unit). Field workers reported being detained in police cells while on duty. They are released only after CARE Bangladesh intervenes.

150 See speech by Mr. Kamaludin Ahmed, reproduced in CARE Bangladesh "Seminar Report Seminar on Harm Reduction Approach in HIV Prevention Program in Bangladesh" (March 2004).

151 Human Rights Watch above n41 at 46.

152 See speech by Mr. Kamaludin Ahmed above n150 and interview with the Unit staff (October 2004, Country visit notes on

however, has not translated into legal protection/immunity for service providers, who continue to function under an environment of uncertainty and ambiguity.¹⁵³

(f) Oral drug substitution

Presently, no oral substitution programs operate in Bangladesh even though the national policy and the strategic plan refer to replacement of injection drugs with oral substitutes as an accepted part of vulnerability reduction measures.¹⁵⁴ According to country experts, discussions have started with NASP and other agencies to introduce a pilot oral substitution programme.¹⁵⁵ Methadone is a banned drug under the Narcotics Control Act.¹⁵⁶ This implies that it cannot be offered to drug users unless substitution programs are recognized as a medical necessity for injection users and a license is issued permitting such use. The DNC is reported to be skeptical about substitution and has questioned the efficacy of 'maintaining persons on drugs' instead of eradicating drug use altogether.¹⁵⁷

(g) Voluntary Counselling and Testing (VCT)

The Government endorses voluntary and confidential counselling and testing for HIV/AIDS and categorically denounces mandatory testing

file with the Unit) which suggests that DNC officials feel that the legislation does not allow them to formally endorse NSEP but they have allowed such interventions to run in the larger interest of HIV prevention and public health. One of the concerns about the harm reduction approach has been that a softer approach towards drug users may result in drug peddlers escaping liability, as the line between the two is thin. See Boeren "Major findings" in CARE Bangladesh "Seminar on Harm Reduction Approach in HIV Prevention Program in Bangladesh: Seminar Report" (March 2004).

153 Interview with Dr. Ziya, Consultant, National AIDS /STD Program, Ministry of Health, Government of Bangladesh (October 2004, Country visit notes on file with the Unit)

154 See National Strategic Plan and National Policy.

155 Interview with Dr. Ziya above n152.

156 See Section 2(6) and First Schedule, Narcotics Control Act.

157 Interview with Kamaludin Ahmed (October 2004, Country visit notes on file with the Unit) and CARE Bangladesh "Seminar on Harm Reduction Approach in HIV Prevention Program in Bangladesh: Seminar Report" (March 2004).

of vulnerable groups.¹⁵⁸ The National Policy lays down detailed guidelines for HIV testing, which can be conducted after provision of counselling. At the time of writing this report, 6 government hospitals had facilities for HIV testing of which half also had counselling services.¹⁵⁹ Two NGOs, namely, Jagori (VCT unit of ICDDR,B) and CAAP have been providing VCT services in certain cities.¹⁶⁰

3.2 Treatment

3.2.1 Drug treatment and rehabilitation

For treatment and rehabilitation of users, four government-supported centres have been operating since 1990 in four cities. Eight medical college hospitals and one mental health institution are treating drug users. About 20 NGOs are involved in demand reduction, of which six offered residential detoxification and care facilities¹⁶¹. BARACA, APON, and CREA are some NGOs offering drug rehabilitation services on a long-term residential basis. Government run outpatient and residential facilities have not been found to be very effective in dealing with drug dependence and addiction.¹⁶²

3.2.2 HIV/AIDS

Access to medication, treatment and care for HIV/AIDS is reportedly not available in Bangladesh. There is very little awareness or training among the medical fraternity on the clinical management of HIV/AIDS cases including treatment of opportunistic infections and dispensation of anti-retroviral therapy. NGOs are primarily focused on prevention efforts and little attention has been paid to concerns of people already infected with

158 National Policy.

159 Communication with Dr. Munir Ahmed above n145.

160 Communication with Zakiur Rehman above n24.

161 South Asia Drug Demand Reduction Report above n4.

162 See Bureau for International Narcotics and Law Enforcement Affairs "International Narcotics Control Strategy Report 2001: Bangladesh" (March 2002). Available at <http://www.state.gov/g/inl/rls/ncrpt/2001/rpt/>.

HIV/AIDS. A working group has been set up within the National AIDS/STD Programme to develop a framework for preventing parent to child transmission of HIV/AIDS.¹⁶³ Support groups for HIV positive people such as Ashar Alo Society have

been formed and are reportedly receiving donor assistance.¹⁶⁴ The Government has touched upon the need to introduce clinical care, institutional, home and community based services as the number of HIV positive cases rise.¹⁶⁵

163 Salim above n20.

164 FHI Country Profile above n23.

165 National Strategic Plan at 16.

III. COUNTRY ANALYSIS – (B) BHUTAN

Bhutan, traditionally named Druk Yul, is a landlocked country located in the eastern Himalayas having a total area of 46,500 square kilometers. It is divided into 20 dzongkhags (districts), composed of 202 gewongs (blocks).

The population of Bhutan is estimated to be between 0.7 million¹ to 2.3 million.² About 47 % of the population is between the ages of 15 and 49 years.³ Only 28% of Bhutanese women are literate as compared to a 56% literacy rate in men.⁴

The Bhutanese economy largely depends on agriculture, which supports about 79% of the population and constitutes 32.7% of the Gross Domestic Product.⁵ Hydropower and tourism are the other sectors that contribute to the economy.⁶

Health services are provided solely by the government and no private health clinics or physicians exist. All district headquarter towns have a hospital. There are about 660 health centres including modern hospitals, basic healthcare units and outreach clinics.⁷ The government accounts for almost 91% of the total expenditure on health.⁸ Despite a high allocation of resources and priority

accorded to the health sector, the available infrastructure cannot cope with people's needs.⁹ There is a severe shortage of health care personnel with official statistics indicating a ratio of 1.7 physicians per 10,000 persons.¹⁰

1. DRUG USE AND HIV/AIDS: RISKS AND VULNERABILITIES

1.1 Drug Use

Compared to neighbouring countries, drug use in Bhutan is still in its nascent stage.¹¹

Marijuana is the most commonly used drug and is smoked, followed by dendrite, an adhesive substance used in industry, which is sniffed.¹² Abuse of pharmaceutical drugs is reportedly on the rise. Cough syrups are in high demand for their codeine content across all age groups of substance abusers.¹³ Apart from cough syrups, use of anxiolytic pills such as Nitrazepam, Calmpose and Diazepam, as well as pain relievers like Morphine, Pethidine and Proxyvon is also reported among drug users.¹⁴ Inhalation of solvents such as glue, petrol and nail polish remover is also reported.¹⁵

While dendrite, petrol and thinners are available in shops, pharmaceutical drugs in tablet form, syrup

1 Official Government estimate, which excludes 0.1 million Bhutanese refugees
2 Figure estimated by international agencies. Basic Statistics, Bhutan News Online available at www.bhutannewsonline.com/at_aglance.html.
3 UNAIDS, UNICEF, WHO "Epidemiological Fact Sheets on HIV/AIDS and Sexually Transmitted Infections: Bhutan (2004 Update).
4 Acharya "Gender equality guaranteed" (8 May 2004), available at www.kuenselonline.com
5 "The Four Pillars of Gross National Happiness" (3 July 2004), available at www.kuenselonline.com
6 Ibid
7 Epidemiological Fact Sheet above n3.
8 Epidemiological Fact Sheet above n3.

9 Epidemiological Fact Sheet above n3.
10 Country Profile: Bhutan, available at <http://w3.whosea.org/eip/annexbhu.htm>
11 Ministry of Health, Bhutan "Situational Report on Drug Abuse: Bhutan" (2004).
12 Epidemiological Fact Sheet above n3.
13 Dorji "Temporary high, permanent damage" (17 February 2004), available at www.kuenselonline.com
14 Epidemiological Fact Sheet above n3.
15 Epidemiological Fact Sheet above n3.

and injectables are smuggled from the border towns of India.¹⁶ Marijuana is grown wildly across the country and is not difficult to obtain.

Besides use of narcotic drugs, consumption of alcohol is reported among young people. Chewing of doma – a betel nut with stimulant properties – is also popular.¹⁷ Though only 1% of the total population is believed to consume tobacco,¹⁸ the government banned the use of tobacco in public places in November 2004.

According to police records in Thimphu, addiction among youth, including students, in the age group of 8–19 years, and among those unemployed is high. Since 1998, the police have arrested 356 substance abusers, of which 60% are under 19 years. 162 drug dependent users were charge-sheeted and are facing trial and 194 drug users were warned.¹⁹ Thimphu recorded the maximum number of narcotic drug-related cases²⁰ while Gasa is the only district that recorded none.²¹ The extent of substance abuse and estimated number of drug dependents in Bhutan is not known.

1.2. Injecting Drug Use

Despite its proximity to Nepal and North-East India, both of which have a high incidence of injecting drug use (IDU), no significant drug injecting is reported in Bhutan. In Phuentsholing, the police have recorded a few cases of youth injecting a solution made from Spasmoproxyvon capsules.²² There are an estimated 30–100 IDUs in Bhutan and so far no case of HIV/AIDS has been detected among them.²³

1.3 HIV/AIDS

As of November 2004, 67 Bhutanese were found to be HIV positive, heterosexual transmission being the primary mode of infection.²⁴ All cases found so far are in the age group of 14 to 45 years. The national adult HIV prevalence rate is less than 0.1%.²⁵

2. DRUG USE AND HIV/AIDS: LAW AND POLICY FRAMEWORK

2.1 Overview of the Legal Framework

Bhutan is a monarchy and the King rules the country with the support of the National Assembly, the Council of Ministers (Cabinet) and the Monastic Body. The National Assembly consists of 150 members, of which 105 are elected by citizens, 10 by a Buddhist clergy and 35 appointed by the King. The present King began the systematic decentralisation of authority in 1981 by delegating some decision-making powers to local bodies at district and block level.²⁶ This paved the way for further decentralisation and, in 2000, the King appointed a Council of Ministers to conduct day-to-day administration.²⁷ The post of the Prime Minister, who is the head of the Council of Ministers, is rotational. It is rotated among six cabinet ministers on an annual basis.²⁸ The Monastic Body comprises of Buddhist clergy headed by four representatives chosen by the King, who watch over the social order.

Laws, based predominantly on theocratic principles were revised during several sessions of the National Assembly in 1950s and Thrimzhung

16 Ministry of Health Report, above n11.

17 "Banned?" (30 August 2004), available at www.kuenselonline.com

18 "Bhutan bans public smoking, tobacco sales" (date), available at <http://www.jointogether.org>

19 Ibid

20 140 cases according to the Ministry of Health Report above n11.

21 Ibid

22 Epidemiological Fact Sheet above n3.

23 Epidemiological Fact Sheet above n3.

24 Wangchuk "Bhutan observes World AIDS Day" (02 December 2004), available at www.kuenselonline.com

25 "Bhutan bans public smoking, tobacco sales" above n18.

26 "The Bhutanese Development Story" (2 February 2004), available at www.kuenselonline.com

27 "Bhutan crafting miniature constitution" (02 December 2004), available at www.kuenselonline.com

28 Political System of Bhutan available at http://www.bhutannewsonline.com/political_system.html

Chenmo (Supreme Law) was brought into force.²⁹ Subsequently, the National Assembly enacted other statutes for the administration of justice. Though the laws are passed with the approval of the Assembly, the body has only nominal legislative powers and the King remains the only real source of law.³⁰

2.1.1 Constitution

Bhutan does not have a written Constitution. There is no protection for fundamental or political rights. The media and press are controlled by the government. The formation of political parties is prohibited and none operate legally.³¹ Similarly, there are no NGOs or civil society in the strict sense of the term in Bhutan.

With a view to having a written Constitution, the King appointed a 39-member constitution drafting committee comprising members of the public, monastic body and the judiciary in 2001.³² Thus far, four drafts of the Constitution have been prepared and the present draft is reported to have 34 Articles.³³ Reports suggest that once finalised, the draft document will be subjected to a national public debate.

2.1.2 Courts

The judiciary comprises the Sub-divisional Court, the District Court and the High Court. Courts have both original and appellate jurisdiction and decide civil as well as criminal cases.

The village Headman has the power to adjudicate minor disputes and petty offences at the village level. These decisions can be reviewed by magistrates who are responsible for a block of

villages. All the 20 districts have district Court each headed by a Drangpon (Judge) and assisted by Drangpon Rabjams (Assistant Judges). There are three sub-divisional Courts in addition to the district Courts. The High Court, known as Royal Court of Justice, was set up in 1968 at Thimphu to review appeals on judgments delivered by district Courts. It consists of Thrimchi Lyonpo (Chief Justice) and seven Drangpons (Judges).³⁴ The King is the highest Court of appeal and can grant pardons or commute punishments.³⁵ The judiciary is not independent as the King exercises direct control.³⁶ Litigants can opt from self-representation to engaging a family member who is conversant with the issues, or to appoint a legal counsel.³⁷

Judges are appointed by the King. For a long period, there were no pre-qualification criteria in place for the appointment of judges and jabmi (legal counsels). The jabmis had existed in the system since the 16th century and used to be persons who were respected in villages and local communities. The government formalised the profession in 1996 by issuing licenses to jabmis and with subsequent enacting of the Jabmi Act in 2004, which lay down guidelines for professional ethics, duties and responsibilities and setting the process of professionalisation. On 30 August 2003, the National Judicial Commission was set up to professionalise and strengthen the system of appointing, censuring, suspending or removing judges of both the Courts.³⁸

2.1.3 The criminal justice system

The National Assembly passed the Civil and Criminal Procedure Code in July 2001 and the Penal Code in 2004. Prior to the enactment

29 Information on the Constitution of Bhutan available at www.cmseducation.org/wconstsbhutan.html.

30 Summary of Bhutan's Legal System, available at www.geocities.com/articlesonbhutan/law_files/bhutan.

31 US Department of State "Country Reports on Human Rights Practices: Bhutan" (2003).

32 Dorji, "Draft Constitution on firm foundation" (8 November 2003), available at www.kuenselonline.com

33 Summary of Bhutan's Legal System, above n30.

34 Dorji above n32.

35 Summary of Bhutan's Political System above n30.

36 Bhutan Newsonline "Political System of Bhutan", available at http://64.233.161.104/search?q=cache:huX_lfUcEysJ:www.bhutannewsonline.com/political_sy

stem.html+judiciary+independence+king+bhutan and hl=en .

37 Wangdi "National Assembly endorses the Jabmi Act" (09 August 2004), available at www.kuenselonline.com .

38 Acharya above n4.

of these laws, there was no clarity as to what constituted a crime and what the penalty for an offence was. Sentences for the same crimes were different in different districts. Reports suggest that judges sometimes award punishments in excess of what is prescribed.³⁹

The newly adopted Civil and Criminal Procedure Code includes institutional, procedural and substantive laws and consolidates other existing acts and relevant provisions of the Thrimzhung Chenmo.⁴⁰ The introduction of the Penal Code marks a significant step towards judicial reform in Bhutan. Various offences are graded under each chapter of the Penal Code and punishment is handed out accordingly.

Offences graded as felonies of the first degree attract punishment of between 15 and 20 years. Punishment for felonies of the second degree ranges between 9 years and 15 years. Felonies of the third degree attract sentences between 5 years and 9 years whereas felonies of the fourth degree are punishable with a minimum of three years but not more than five years. The King, vide a *Kasho*⁴¹ issued on 20 March 2004, abolished capital punishment in Bhutan.

Laws are enforced by the police, with assistance from judges, who investigate cases, file charges, prosecute and award judgments.⁴²

2.2 Drug Use and HIV/AIDS Harm Reduction Law

2.2.1 General penal provisions

Aid and Abetment⁴³ of a crime and criminal

attempt⁴⁴ to commit a crime are punishable offences under the Bhutan Penal Code. Soliciting, requesting, commanding or causing another person to commit a crime is also punishable under the Code.⁴⁵ Harm reduction programmes can be labelled as criminal conspiracy to commit a crime.⁴⁶ Persons engaged in NSEPs can be held liable as accomplices⁴⁷ as they may help a person commit a crime

HIV/AIDS public education campaigns related to drug use may be punishable as lewd and lascivious conduct.⁴⁸

2.2.2 Drug use

(a) Legislative history

Offences relating to the illicit use of drugs are covered to a large extent under the Bhutan Narcotic and Psychotropic Substances and Substance Abuse (NDPSSA) Act, 2005. However to a small extent the Bhutan Penal Code also contains provisions for drug use.

Offences under the Bhutan Penal Code

Unlawful cultivation, production or manufacturing of the following controlled substance is an offence, namely:-

- ◆ Coca plant or any of its derivatives including cocaine;
- ◆ Opium, poppy or any of its derivatives;
- ◆ Any narcotic drug or psychotropic substance; or
- ◆ Any controlled medicinal products and precursor chemicals.⁴⁹

Illegal transaction (import, export, sale, purchase, hoarding and storage or transportation) of any

39 Ibid

40 Asian Development Bank "Country Strategy and Programme Update" (2003-2005), available at www.adb.org/Documents/CSPs/BHU/2002/csp0100.asp

41 'Kasho' means royal edict

42 Summary of Bhutan's Legal System, above n36.

43 Sec 125, Bhutan Penal Code, "a person shall be guilty of the offence of aiding and abetting a crime, if the defendant engages in a conduct designed to accommodate or help another person in the commission of a crime".

44 Sec 120, Bhutan Penal Code,

45 Sec 126

46 Sec 127

47 Sec 64

48 Sec 381(b)

49 Secs 496 and 497

narcotic drug or psychotropic substance is punishable as an offence.⁵⁰

Possession or use⁵¹ of a narcotic drug or psychotropic substance without the prescription of a registered doctor is an offence. The offence attracts greater penalty if the amount possessed is of a quantity as to convince the Court that the defendant intended to sell it.⁵²

The NDPSSA Act

(b) Nature and classification of prohibited substances

Each of the plants, drugs and substances within the ambit of Narcotics Drugs and Psychotropic Substances and Substance Abuse (NDPSSA) Act, 2005 is classified by the schedule in which it appears. Different measures of control are specified for different plants, drugs and substances according to the classification to ensure that drugs are available exclusively for medical, veterinary and scientific purposes. Strictest measures are applied to those listed in schedule I, less strict measures in relation to those listed in schedule II, and the least strict in relation to those listed in schedule III. Additionally there are schedules IV and V which deal with precursor and controlled substances respectively that are used in the manufacture of narcotic and psychotropic substances.

Schedule I of the NDPSSA Act contains prohibited substances and plants having no medical use. It comprises:

- ◆ Schedule IV of the Single Convention on Narcotic Drugs⁵³, 1961 and
- ◆ Schedule 1 of the Convention on Psychotropic Substances⁵⁴, 1971.

- ◆ Schedule II consists of strictly controlled substances and plants having a medical use. It comprises:
- ◆ Schedule I and II of the Single Convention on Narcotic Drugs, 1961
- ◆ Schedule II of the Convention on Psychotropic Substances, 1971.

Methadone, a drug that is extensively used in the drug maintenance programmes is listed in Schedule II along with coca leaf, cocaine and its derivatives, morphine and opium.

Schedule III consists of controlled substances and plants having a medical use. It comprises:

- ◆ Schedule III of the Single Convention on Narcotic Drugs, 1961 and
- ◆ Schedule III and IV of the Convention on Psychotropic Substances, 1971.

The list includes, Buprenorphine, another drug popularly used in drug substitution programmes.

Schedule IV includes the precursors⁵⁵ that are used in illicit manufacture of narcotic drugs and psychotropic substances. Schedule V includes other controlled substances that are liable for abuse but do not fall under International control.

Preparations⁵⁶ are subject to the same measure of control as the drugs of abuse or controlled chemicals they contain, and where any preparation contains two or more constituent drugs of abuse, it is subject to measures governing the most strictly controlled constituent.

50 Sec 498

51 Sec 500

52 Sec 501

53 Sec 108 (xvi) defines narcotic drug to mean "a substance listed in any of the schedules annexed to the Single Convention on Narcotic Drugs, 1961, as amended"

54 Sec 108 (xx) defines psychotropic substances to mean, "a substance

listed in any of the schedules annexed to The Convention on Psychotropic Substances, 1971."

55 Sec 108 (xvi) defines precursor to mean, "a substance listed in the schedule to the United Nations Convention on Illicit Traffic in Narcotic Drugs and Psychotropic Substances, 1988."

56 Sec 108 (xvii) defines "preparation" to mean, "a mixture, solid or liquid, containing a drug or precursor."

(c) *Offences and penalties*

The NDPSSA Act prohibits any person not expressly licensed for the purpose the following activities in relation to narcotic drugs and psychotropic substances:

- ◆ Cultivation⁵⁷
- ◆ Production⁵⁸
- ◆ Manufacture⁵⁹
- ◆ Wholesale and retail trading and distribution⁶⁰
- ◆ Import and export⁶¹
- ◆ Use⁶²
- ◆ Possession for any purpose⁶³
- ◆ Advertising except with approval, in scientific or professional publications for researchers or health professionals.⁶⁴
- ◆ Distribution or dispensing to individuals of samples of substances or preparations listed in Schedules II and III.⁶⁵

The NDPSSA Act also makes the following acts as offences, namely:-

- ◆ Transportation, transshipment and storage for medical and scientific purposes in contravention of terms or conditions of a license.⁶⁶
- ◆ Illegal transaction of any precursor.⁶⁷
- ◆ Manufacture, transportation or distribution of any equipment or material for unlawful cultivation, production or manufacture of drugs.⁶⁸
- ◆ Cultivation of opium, poppy and coca bush.⁶⁹

- ◆ Cultivation and domestication of cannabis. Harvesting or collecting of cannabis except for production of fibre and animal feed.⁷⁰
- ◆ Solicitation to unlawfully use drugs or controlled substance.⁷¹
- ◆ Unauthorised advertising of controlled drugs to public.⁷²
- ◆ Knowingly using proceeds of crime.⁷³

The existence of aggravating circumstances attracts higher penalty.⁷⁴ These include circumstances such as if an offence under this Act or the Penal Code of Bhutan is committed by a health professional or a person responsible for combating drug abuse or traffic, in a teaching or educational institution, a hospital or care institution, a social service facility or in other places to which school children or students resort for educational, sports or social activities or in the immediate vicinity of such establishments and premises; in a penal institution or a military establishment; or if the drug was supplied or offered to a minor, a mentally handicapped person or a person undergoing treatment, or when the use by such a person was facilitated.

(d) *Powers and procedures*

Any officer authorised by the Narcotics Control Board (NCB) has the power to search, seize, arrest and detain in accordance with the Civil and Criminal Procedure Code of Bhutan.⁷⁵ In respect of offences under the NDPSSA Act and the Penal Code of Bhutan, samples can be taken of a seized substance⁷⁶ in accordance with the procedure laid down under the law⁷⁷. The Court may order confiscation⁷⁸ of any property derived through

57 Sec 8 "The cultivation, production, manufacture, wholesale and retail trading and distribution, import, export and use of the plants

58 Sec 90

59 ibid

60 ibid

61 ibid

62 ibid

63 Sec 13

64 Sec 15

65 Sec 16

66 Sec 90

67 Sec 94

68 Sec 95

69 Sec 97

70 Sec 98

71 Sec 100

72 Sec 101

73 Sec 96

74 Sec 102

75 Sec 70

76 Sec 72

77 Sec 72

78 Sec 73

commission of an offence against the NDPSSA Act or the Penal Code of Bhutan. Further if the Court is of the opinion that the property that has been seized represents any person's proceeds or is intended to be used in illicit trafficking, it may order the forfeiture of that property.⁷⁹ The drugs seized or confiscated or forfeited shall be disposed off⁸⁰ in the presence of members of the NCB and/or officials of the authorised agencies. If the drug is listed in Schedule II or III, then disposal would include using the drugs to meet the health care needs of Bhutan⁸¹.

The NDPSSA provides for some special investigative techniques of controlled delivery and undercover operations. Authorised agencies upon approval by the NCB can allow the use of controlled delivery and undercover operations within Bhutan, and at an international level, with a view to identifying persons engaged in the offences under this Act and gathering appropriate information and evidence to take action against them.⁸²

Any person, private or public enterprise, Royal Government enterprise, medical or scientific institution engaging in any activity or operation involving plants, substances or preparations covered by this Act shall be subject to inspections. Ordinary inspections of the establishment, premises, stocks and records happen once every two years and extraordinary inspections can happen any time. Such inspections have to be carried out in accordance with the Civil and Criminal Procedure Code of Bhutan.⁸³

Persons, enterprises or establishments involved must provide inspectors and the Royal Bhutan Police with all necessary assistance in carrying out their duties, in particular by facilitating inspection of their professional premises and of all documents related to their professional

activities.⁸⁴ Obstruction of lawful authority⁸⁵, hindering prosecution⁸⁶ and failure to assist lawful authority⁸⁷ are punishable offences under the Bhutan Penal Code.

(e) *Statutory bodies*

The NDPSSA Act 2005 establishes the following statutory bodies:

- ◆ The Narcotic Control Board (NCB)⁸⁸
- ◆ The Bhutan Narcotics Control Agency (BNCA)⁸⁹
- ◆ The Supply Reduction Committee (SRC)⁹⁰
- ◆ The Demand Reduction Committee (DRC)⁹¹
- ◆ The Treatment Review Committee (TRC)⁹²

The NCB is constituted to take all measures for preventing and combating abuse and illicit trafficking and to regulate the use of narcotic drugs, psychotropic substances and other controlled substances.⁹³ In addition, the NCB has the power to regulate treatment, rehabilitation and social reintegration of drug users.⁹⁴ The NCB may constitute committees for effective exercise of powers and discharge of functions.⁹⁵

The BNCA is established and has the power to acquire information from any agency designated by the NCB relating to the implementation or enforcement of the provisions of this Act⁹⁶. The BNCA serves as the Secretariat to the NCB and implements its decisions.⁹⁷ It is also responsible for proposing, revising and implementing

79 Sec 74

80 Sec 77

81 Sec 78

82 Secs 81, 82 and 83

83 Sec 26

84 Sec 30

85 Sec 422, Bhutan Penal Code

86 Sec 420, *ibid*

87 Sec 428, *ibid*

88 Sec 59

89 Sec 64

90 Rule 10.1 of the Narcotic Drugs, Psychotropic Substance and Substances Rules and Regulations, hereinafter NDPSS Rules

91 Rule 10.2 of the NDPSS Rules

92 Rule 10.3 of the NDPSS Rules

93 Sec 59

94 Sec 61(e)

95 Sec 61(h)

96 Sec 68 NDPSSA

97 Sec 69 (a)

Bhutan's national drug control strategy or prevention, reduction and eradication of drug abuse, illicit drug supply and drug related crime.⁹⁸ The BNCA has the mandate to strengthen technical and operational skills of various agencies, government, private as well as the community through research and analysis;⁹⁹ to improve international cooperation against drug and precursor trafficking;¹⁰⁰ secure cooperation among various agencies towards drug prevention and control in Bhutan, to reduce illicit drug supply and drug-related crime;¹⁰¹ administer and enforce the provisions of the NDPSSA Act to the extent designated by the NCB, facilitate enforcement of the Act by other agencies, refer matters for investigation and appropriate action in case of contravention of the Act;¹⁰² and to monitor the enforcement of the provisions of the NDPSSA Act.¹⁰³

Under section 61(h) of the NDPSSA and Rule 10.1 of the NDPS Rules, the NCB constituted a Supply Reduction Committee (SRC) to advise itself and the BNCA on technical matters. The main objectives of this Committee are:

- ◆ Review and assess the drug abuse situation in Bhutan.
- ◆ Identify weaknesses in enforcement procedures.
- ◆ Give advice on supply reduction strategies.

In addition to SRC, the NCB has also established a Demand Reduction Committee (DRC), entrusted with the following tasks:

- ◆ Develop demand reduction strategies and ensure their implementation.
- ◆ Provide preventive support and protection including life skills education.

- ◆ Ensure early detection and counselling services.
- ◆ Plan recreational activities and other vocational opportunities to promote social integration.¹⁰⁴

Under section 57 of the NDPSSA, the NCB has constituted a Treatment Review Committee (TRC).¹⁰⁵ The main functions of the TRC are:

- ◆ To review and assess treatment facilities at approved treatment and rehabilitation centres including personnel and environment.
- ◆ To advise and direct institution of new, suitable facilities.

(f) *Treatment and rehabilitation*

The NDPSSA has extensive provisions for treatment¹⁰⁶ enacted on the underlying principle that drug dependent persons are victims of unfortunate circumstances and should have the option to avail treatment, rehabilitation and social reform instead of criminal charges and confinement.¹⁰⁷

Importantly, treatment has been defined as, "treatment includes medical treatment, therapy or admission to an education or rehabilitation programme, social reintegration which is aimed at preventing drug abusers from further abusing drugs, and assisting drug dependent persons to overcome their dependence".¹⁰⁸ An addict has been defined to mean "a person addicted to any narcotic drug or psychotropic substance, and it is used synonymously with drug user."¹⁰⁹ "Drug" means any substance listed in schedule I, II or III whether natural or synthetic.¹¹⁰

98 Sec 69 (b)
99 Sec 69 (c)
100 Sec 69 (d)
101 Sec 69 (e)
102 Sec 69 (f)
103 Sec 69 (g)

104 Sec 10.2 and Rules and Regulations 2006
105 Sec 10.3 and Rules and Regulations 2006
106 Chapter Six of the NDPSSA Act
107 Sec 52, NDPSSA
108 Sec 108 (xxi) NDPSSA
109 Sec 108 (i) NDPSSA
110 Sec 108 (xii) NDPSSA

The NCB is required to ensure establishment of institutions with facilities for early identification of drug users through mobile camps, outreach services with appropriate testing facilities¹¹¹ among other interventions. The NCB is also responsible for ensuring services for treatment and rehabilitation of drug dependent persons at approved treatment centres¹¹² with adequate staffing.¹¹³ The TRC is required to review the quality and range of services offered by such institutions periodically. Additionally, Treatment Assessment Panels are to be established by the NCB to maintain quality and standards of services at such institutions.¹¹⁴

A person, guilty of an offence under section 500 of the Bhutan Penal Code¹¹⁵ shall not be prosecuted or identified to the public, provided:

- ◆ s/he voluntarily presents to an approved treatment centre before being arrested or charged for that offence, and
- ◆ undertakes to and successfully completes treatment without committing any further offence.¹¹⁶

If a person is charged only with an offence under section 500 of the Bhutan Penal Code, the Court before whom such person is charged can order the accused to report to an approved treatment centre. If the person undertakes and successfully completes the treatment without committing any further offence, the Court may allow charges to be withdrawn¹¹⁷

Where any offence other than possession of a drug without prescription is proved, the Court may order the accused to submit for assessment by a

Treatment Assessment Panel if, in its opinion, the person may have been:

- ◆ under the influence of a narcotic drug or psychotropic substance at the time of the offence; or
- ◆ motivated to commit the offence by a desire either to use the substance or to obtain resources to enable its use.¹¹⁸

Where the panel recommends that person undergo treatment at an approved treatment centre, the Court may order that the person submit himself/herself for the specified treatment for a period of upto two years and may impose conditions for the same.¹¹⁹ Where such an order is made and the person promises to undertake and complete the treatment, the Court may suspend the penalties or sanctions imposed in respect of the offence.¹²⁰ Where a person successfully completes the treatment and commits no further offence within two years from the date of conviction, the Court may discharge penal sanctions against the person, provided the Court is satisfied that:

- ◆ It is in public interest to make such an order.
- ◆ On consideration of the report of the Panel that the person is fit to return to everyday responsibilities and functions.¹²¹

However if the person doesn't complete the prescribed treatment, the order of suspension of penal sanctions may be revoked¹²² and time spent in treatment will be counted as time towards discharge of the penalty.¹²³

A drug dependent person who submits voluntarily for treatment and is released temporarily from

111 Sec 36 NDPSSA

112 Sec 37, NDPSSA and Sec 10.3, NDPSSA Rules and Regulations 2006

113 Sec 38, NDPSSA

114 Sec 40, 41 NDPSSA

115 Sec 500 of Bhutan Penal Code provides that a person "shall be guilty of the offence of possession of a controlled substance if s/he possesses narcotic drug or psychotropic substance without the prescription of a registered doctor"

116 Sec 42 NDPSSA

117 Sec 43 NDPSS

118 Sec 44

119 Sec 45

120 Sec 46

121 Sec 47

122 Sec 48

123 Sec 49

the centre, is to be provided after-care, follow-up treatment and supervision.¹²⁴

A person who has been ordered to undergo treatment will commit an offence if she/he without reasonable cause refuses or fail to:

- ◆ comply with a treatment order;
- ◆ inform the person in-charge of his treatment of change in her/his address;
- ◆ appear before a panel as ordered;
- ◆ attend a treatment centre for assessment or treatment as ordered.¹²⁵

If a drug user escapes and recommit an offence, s/he is subjected to stricter charges and confinement.¹²⁶ A drug user who refuses to submit to treatment will be compulsorily confined to criminal custody¹²⁷ and if s/he is charged with an offence, will be liable to compulsory submission to treatment and rehabilitation.¹²⁸

Breach of confidentiality of records under the voluntary submission programme is a punishable offence.¹²⁹ However communication of information to and between members of the TRC or to and between persons directly involved in the protection and rehabilitation of the drug dependent will not amount to breach of confidentiality.

2.3 Drug Use and HIV/AIDS Harm Reduction Policy

2.3.1 Drug use

Bhutan does not have a drug policy. It appears that some schools have formulated policies as substance use among school children is on the

rise. A certain school policy provides counselling for students and spot checks in hostels.¹³⁰

2.3.2 HIV/AIDS

In 1988, the government established the National HIV/AIDS and STD Control Programme. In 1989, a 16-member National AIDS Committee (NAC) was formed comprising senior government representatives from various ministries and prominent community members. It is supported by the National AIDS Technical Committee consisting of representatives from the health sector.¹³¹ Reports suggest that a Medium Term Plan for Prevention and Control of AIDS was in force during 1990 to 1993¹³², at the time when the first case of HIV/AIDS was detected.

Presently, there is no formal policy on HIV/AIDS. However, the government released a Kasho in August 2004 containing information on spread of HIV. The Kasho advocates non-discrimination against HIV positive people, maintaining confidentiality regarding a person's HIV status and being compassionate towards HIV-positive people.¹³³

The health chapter in the Ninth Five Year Plan (2002-07) identifies HIV as a challenge and notes that a high prevalence of STIs in some pockets and proximity to a region with high incidence of STI and HIV, HIV may assume epidemic proportions in Bhutan. It emphasises the need for strengthening information, education and communication for prevention and for monitoring the spread of STI/HIV/AIDS.¹³⁴ A multi sectoral task force has been set up in each district. Chaired by the District Governor, the task force is responsible for identifying, prioritizing and responding to public

124 Sec 51

125 Sec 50

126 Sec 53

127 Sec 54

128 Sec 55

129 Sec 56

130 Dorji "Policy needed to promote a drug free society" (13 March 2004), available at www.kuenselonline.com

131 UNDP report "Accelerating threat of HIV/AIDS in Bhutan" (January 2003), available at www.undp.org.bt/HIVAIDS/HIVAIDS_DISCUSSION_PAPER.PDF.

132 Basic Statistics above n2.

133 "Kasho emphasises the threat of HIV/AIDS" 7 August 2004, available at www.kuenselonline.com

134 "Accelerating threat of HIV/AIDS in Bhutan", January 2003, UNDP report

health concerns. Additionally, the task force is responsible for creating awareness about HIV/AIDS among the general population in the district.

3. DRUG USE AND HIV/AIDS HARM REDUCTION PRACTICES

The World Bank has sanctioned US\$ 5.7 million (approximately Nu 250.25 million) in 2004 for Bhutan's HIV/AIDS project that is spread over five years.¹³⁵ In addition to the World Bank loan, the government has committed Nu 65 million during the ninth plan (2002-07) for prevention, awareness and treatment.¹³⁶

The Government of Denmark has been providing financial assistance to Bhutan since 1990 under the Health Sector Programme Support (HSPS) for general health. HIV/AIDS prevention and control activities have also been included under HSPS.¹³⁷

3.1 Prevention

3.1.1 Drug use

There is no formal body that works on demand reduction aspects of illicit drug use. Sporadic attempts include a workshop on drug abuse for law enforcement, Ministry of Health and teachers and parents by the Education Ministry's Department of Youth, Culture and Sports and Colombo Plan's Drug Advisory Programme. Though there were different recommendations for issuing a clear national policy and formation of a national committee, there was unanimous agreement on the need to act fast to prevent growing drug use and dependence in Bhutan.¹³⁸

3.1.2 HIV/AIDS

(a) IEC/BCC

Accurate knowledge about HIV/AIDS transmission and methods of prevention appears to be low amongst the general population. A survey among students revealed high levels of misinformation about HIV/AIDS.¹³⁹ Knowledge among health care workers and counsellors was also reported to be inadequate.¹⁴⁰

Of the US\$ 5.7 million World Bank-funded HIV/AIDS project, US\$ 1 million has been allocated for producing audio-visual material for creating awareness.

(b) STI treatment

No information available on treatment/services for STIs.

(c) Condom promotion

There does not appear to be any restriction by law on condom promotion and distribution. The Health Ministry is making efforts to promote condom usage among the general population. However, social and cultural norms make it difficult for people to access condoms.¹⁴¹

The HIV/AIDS project has allocated US\$ 2 million for condom promotion.

(d) VCT

Some reports suggest that HIV tests are offered at government hospitals, free of cost.¹⁴² Information about the number and nature of HIV/AIDS counselling and testing facilities was not available.

135 "Kasho emphasise threat of HIV/AIDS" above n68.

136 Wangdi "HIV toll rises" (06 December 2004), available at www.kuenselonline.com.

137 Asian Development Bank "Country Assistance Plans: Bhutan", available at www.adb.org/Documents/CAPs/BHU/0303.asp.

138 "Kasho emphasise threat of HIV/AIDS" above n68.

139 Ibid

140 Ibid

141 "Dealing with HIV" (15 May 2004), available at www.kuenselonline.com

142 "Dealing with HIV" 15 above n76.

It appears from news reports that certain sections of the population are screened for HIV/AIDS. Pregnant women, however, are not routinely tested.¹⁴³ Contact tracing is carried out in the event of a person testing HIV positive.

(e) NSEP

There are no NSEPs in Bhutan.

(f) Oral drug substitution

No oral drug maintenance / substitution programs exist in Bhutan.

3.2 Treatment

3.2.1 Drug treatment and rehabilitation

There are reportedly no drug treatment and rehabilitation centres in Bhutan. Drug users have to access treatment centres in neighbouring India or in some other country. Anecdotal reports suggest that two recovering users have come

143 Wangmo "Seven more HIV cases detected" (16 October 2004), available at www.kuenselonline.com.

forward to set up a treatment center – 'REWA (Hope) in Bhutan, which will be financed out of the Youth Development Fund, set up by the King. This initiative however, remains unconfirmed. The government was also considering the proposal seriously due to deaths of three drug users caused due to overdose.¹⁴⁴ However, the YDF website lacks information on the progress of this initiative.¹⁴⁵

3.2.2 HIV/AIDS

Following the recommendation of the NAC, the government began anti-retroviral (ARV) treatment in August 2004¹⁴⁶ for those who need it. The NAC also directed the Health Ministry to set up a laboratory and train healthcare workers for the administration of ARV drugs.¹⁴⁷ The government will be spending US\$ 300 a year per patient for providing ARV drugs.¹⁴⁸

144 Wangdi "Support centre for drug addicts" (5 October 2004), available at www.kuenselonline.com

145 Youth Development Fund, available at <http://www.youthdevfund.gov.bt/>.

146 "Seven more HIV cases detected" above n78.

147 Wangdi "Anti-retroviral drugs for HIV patients" (21 August 2004) available at www.kuenselonline.com

148 Ibid.

III. COUNTRY ANALYSIS – (C) INDIA

India is the largest country in the SAARC region with the second largest population in the world, estimated at about 1.15 billion people.¹ It epitomizes the demographic and health profile of the South Asian region, characterized by high rates of infant and maternal mortality, low levels of literacy and poor access to health care.²

1. DRUG USE AND HIV/AIDS: RISKS AND VULNERABILITES

1.1. Drug use

Opium and cannabis have been the traditional drugs of use in India with moderate consumption being ritualized at social gatherings. During Shivaratri and Holi, everyone, male and female, drinks a beverage made from cannabis leaves and dry fruits as part of the festivities³. Traditional use continues till date. In the mid-1970s and the early 1980s, use of cannabis, opium, methaqualone, barbiturates, and minor tranquillizers was seen especially among young people⁴. Some abuse of amphetamines, LSD and cocaine was also reported. Heroin use was first reported in 1985. The introduction of heroin in drug markets across South Asia, including India, is believed to coincide with international

political events⁵ and domestic legislative developments.⁶

According to latest official surveys, alcohol, cannabis (ganja, marijuana, charas), opium and heroin are the main drugs used in the country.⁷ There are an estimated 73.54 million persons dependent on drugs in India, of which 62.46 million were addicted to alcohol, 8.75 million cannabis users, 2.04 million opiate users, and 0.29 users of sedative hypnotics.⁸ There is considerable diversity in the extent and pattern of substance use across the country.⁹ Sex and gender data disaggregates clearly show that drug use is predominantly a male phenomenon.¹⁰ Drug use among women exists but is largely invisible.¹¹ It is only recently that drug use among

1 Indian Census (2004), available at <http://www.censusindia.net/results/resultsmain.html>.
2 UNICEF "Country Statistics: India", available at http://www.unicef.org/infobycountry/india_statistics.html.
3 UNODC, Government of India "Women and Drug Abuse: The Problem in India (2002) at 31. Hereinafter Women and Drug Abuse.
4 Centre for Harm Reduction "Revisiting the Hidden Epidemic" available at <http://www.chr.asn.au/freestyler/gui/files/India.pdf>

5 The Iraq-Iran and the Russian-Afghan wars across the western border of India are known to have flooded the Indian markets with cheap quality heroin or brown sugar, which was popularly known as 'smack'.
6 The enactment of the Narcotic Drugs and Psychotropic Substances Act, 1985 created a stringent, non-tolerant environment around drug use. The penalisation of opium under the Act is believed to have been a significant factor in the shift towards heroin consumption. See UNAIDS, UNODCCP "India" in Drug Use and HIV Vulnerability: Policy Research Study in Asia, Task Force on Drug Use and HIV Vulnerability (October 2000) at 56
7 UNODC, Government of India "The Extent, Patterns and Trends of Drug Abuse in India" National Survey (2004) at 3; hereinafter the National Survey. The National Survey takes combines the inputs from the National Household Survey on Drug and Alcohol Abuse (NHS), the Drug Abuse Monitoring System (DAMS), the Rapid Assessment Survey (RAS) and Focused Thematic Studies on Drug Abuse among Women, Burden on Women due to Drug Abuse among Family Members, Drug Abuse among Rural Population, Availability and Consumption of Drugs in Border Areas, Drug Abuse among Prison Population. Most of the data was collected in 2000, however the NHS was carried out in 2001.
8 National Survey at 87.
9 National Survey at 90-2.
10 Avert "HIV and AIDS in India", available at <http://www.avert.org/aidsindia.htm>.
11 Ibid.

women has been documented.¹² The commonly used drugs among female drug users were heroin, propoxyphene, alcohol and minor tranquillizers.¹³ In addition to women, other sub-populations among which substance dependence was documented by the National Survey include street children, adolescents and prisoners.¹⁴ However, the extent and pattern of such use could not be ascertained because of the difficulty in accessing these populations. Drug use was also documented in rural areas.¹⁵

1.2 Injecting Drug Use (IDU)

The trend of injecting drugs was seen in the 1990s in metropolitan cities – Delhi, Mumbai, Chennai and Kolkata; the same sites that witnessed growing heroin (brown sugar) addiction throughout the 1980s.¹⁶ Additionally, the northeastern states, in particular Manipur, reported widespread injecting of 'white sugar', a purer variety of heroin than brown sugar. By the mid- to late 1990s, IDU was well established in places like Imphal.¹⁷ Injection of prescription drugs, notably Buprenorphine (popularly called Tidigesic), Diazepam and Spasmoproxyvon was also reported around the same time.¹⁸

Rapid Situation Assessments conducted in two rounds found a rising proportion of IDUs in 14 cities.¹⁹ About 14.3% of those seeking treatment reported having ever injecting drugs.²⁰ Nationwide figures for prevalence of IDU are, however, not available. Data from the National Household

Survey reports that about 0.1% of the sample population had ever injected drugs. This figure is believed to be an underestimation and has not been used to project an absolute figure of IDUs in the country.²¹ A small proportion of women and prisoners injected drugs.²² Among drug users on the street, about 43% were injecting drugs.²³

The socio-demographic profile of injecting drug users is similar across cities, except Manipur. The overwhelming majority is male, with little or no education. Most survive on the streets amidst extreme poverty and squalor with no contact with formal health or social structures.²⁴

The switch from smoking/inhaling to injecting drugs has, thus far, been explained by speculative reasoning. Those working closely with IDUs contend that the pattern of use is impacted by the availability and price of drugs and also population mixing.²⁵ This, some feel, is borne out by the Indian experience of heroin smokers/chasers during the 1980s and 1990s.²⁶ It is believed that efforts to curb heroin supplies after the passage of the anti-narcotics law in 1985 resulted in 'heroin droughts' and a sharp hike in street price. Faced with agonizing withdrawal, many heroin dependent users sought medical assistance that included administration of injectable buprenorphine for managing withdrawal.²⁷ This, along with shortage of heroin, is believed to have led drug users towards drug injecting, a more cost-effective way of getting 'high'. Mixing of IDUs with non-injecting users

12 See "Women and Substance Abuse in different regions of the world" in UNODC "Substance abuse treatment and care for women: Case Studies and lessons learned" Drug Abuse Treatment Toolkit (New York, 2004) at 6.

13 "Women and Drug Abuse" above n3 at 31.

14 National Survey at 61 and 73.

15 National Survey at 53.

16 "Revisiting the Hidden Epidemic" above n4.

17 Ibid

18 Dorabjee and Samson, SHARAN "A multicentre rapid assessment of injecting drug use in India" International Journal of Drug Policy Vol. 11 (2000) at 99-112.

19 Ministry of Social Justice and Empowerment, Government of India, UNODC ROSA, UNAIDS "Injecting Drug Use and HIV/AIDS in India: An Emerging concern" (December 2004).

20 National survey at 77.

21 "The Extent, Patterns and Trends of Drug Abuse in India" above n7.

22 "Injecting drug use and HIV/AIDS in India" above n19 at ix.

23 UNODC "Formation of peer networks to address HIV risks in injecting drug user populations (North-east India and metropolitan cities of India)", available at <http://www.unodc.org/india/en/peernetworks.html>.

24 Dorabjee, Samson, SHARAN "Self and Community Based Opioid Substitution among populations in the Indian sub continent", available at <http://www.drugtext.org/library/articles/dorabjee.htm>.

25 Manning, "Conceptualising the Diffusion of Injecting Drug Use in Delhi as a consequence of Drug Control and Development Policies" 1999 (Unpublished, on file with the Unit).

26 Interview with Greg Manning, SHARAN, New Delhi.

27 Dorabjee above n18.

is further said to have 'popularised' injecting drug practices among peers.²⁸ Though official reports attribute the phenomenon of injecting drug use to non-availability of heroin²⁹, a link between narcotics law enforcement and drug consumption patterns is yet to be acknowledged. Official studies have, however, noted with concern the potential among opiate users to switch to drug injection, within a time period ranging from two to ten years.³⁰

Adverse health consequences of injection drug use have been documented in India. Fever, diarrhoea, tuberculosis, sexually transmitted infections, abscesses, impairment and deaths related to drug overdose are among the frequently reported health problems by IDUs.³¹ The threat of blood borne infections such as Hepatitis C and HIV/AIDS is borne out by unsafe drug injecting practices. Sharing of injection equipment including needles, syringes, water, cotton, use of contaminated needles and incorrect cleaning practices has been observed at sites across the country.³² In addition to risky injection practices, unsafe sexual activity is also reported among IDUs.³³ At the same time, IDUs did not perceive themselves to be at risk of HIV transmission and only a small proportion has reportedly undergone HIV testing.³⁴ The risk of HIV infection to wives/sexual partners of IDUs on account of low condom use³⁵ has been viewed as a serious public health concern.³⁶

HIV prevalence among IDUs varies widely across cities. While seropositivity among injectors was

found to be as high as 80.7% in Imphal, in Kolkata only 2% of IDU were HIV positive.³⁷

In some of the north-eastern states, the spread of HIV/AIDS to the general population has been attributed to HIV infection among IDUs.³⁸ At the end of 2003, national epidemiological data attributed 2.2% of total HIV infections to injecting drug use.³⁹

1.3 Other Vulnerabilities

(a) Street children

Substance abuse is not uncommon among poor, marginalized children living off the streets in urban cities. Studies reveal that addiction among children begins with tobacco, which is smoked as bidis or cigarettes or chewed as gutka and develops into a habit of sniffing cheap solvents like correction fluid, glues, petrol that are inhaled.⁴⁰ Alcohol and cannabis addiction is also reported among older children.⁴¹ Till date, there are no reports of injecting drug use among drug dependent children.⁴²

Children and adolescents living on the streets are also believed to be at risk of contracting HIV/AIDS through unprotected sex. Studies have found children and adolescents to be sexually active with peers as well as adults, and in both coerced and non-coerced situations.⁴³ This is evidenced by the fact that over 50 % of all new

28 Manning above n25.

29 "Injecting Drug Use and HIV/AIDS in India" above n19 at 7.

30 National survey.

31 "Injecting Drug Use and HIV/AIDS in India above n19 at 18.

32 Ibid at 11.

33 National AIDS Control Organisation "Part II: MSM and IDUs" of "National Baseline High Risk and Bridge Population Behavioural Surveillance Survey" (2002), available at <http://www.nacoonline.org/publication.htm>.

34 Ministry of Social Justice and Empowerment, Government of India and UNODC ROSA "Rapid Assessment Survey of Drug Abuse in India" (2002) at 16.

35 National AIDS Control Organisation Survey above n33.

36 "Injecting Drug Use and HIV/AIDS in India" above n19 at 16.

37 Table 2: Estimated number of IDUs, HIV prevalence and drug treatment availability in Dorabjee above n18.

38 "Injecting Drug Use and HIV/AIDS in India" above n19 at 16.

39 National AIDS Control Organisation "An overview of the spread and prevalence of HIV/AIDS in India", available at www.nacoonline.org/facts_overview.htm.

40 Pagare, Meena, Singh and Saha, "Risk Factors of Substance Use Among Street Children from Delhi" (2003), available at <http://www.indianpediatrics.net/mar2004/mar-221-225.htm>.

41 Benegal, Bhushan, Sheshadri and Karott, "Drug Abuse among street children in Bangalore" (collaborative project between NIMHANS, Bangalore and the Bangalore Forum for Street and Working Children, 1998), available at http://www.nimhans.kar.nic.in/deaddiction/lit/DrugAbuse_StreetChildren_Bangalore.pdf.

42 National AIDS Control Organisation Survey above n33.

43 HIV/AIDS Forum "HIV/AIDS Resources", available at <http://www.indiangos.com/issue/hiv/resources/children.htm>.

HIV infections in India take place among young adults below 25 years.⁴⁴

1.4 HIV/AIDS

India has the second largest estimated population of HIV persons – at 5.13 million as of December 2004 – with an overall sero-prevalence of 0.91%.⁴⁵ The first case of HIV was detected in a commercial sex worker in Chennai in 1986.⁴⁶ Over the last two decades, the epidemic has seen a steady rise, witnessing a sharp increase in the number of new infections in the period between 1990 and 1998.⁴⁷

Sentinel surveillance was instituted in 1994 to track the spread and prevalence of the epidemic. While nationally prevalence remains low, some states have been characterized as having a 'high prevalence' i.e. the rate of infection among women attending antenatal clinics has crossed 1%.⁴⁸ Gujarat, Goa and Pondicherry are classified as states with moderate prevalence while the rest have low prevalence of HIV/AIDS.⁴⁹

The predominant route of transmission is unprotected sex but the northeastern states have witnessed IDU driven epidemics. While 75% of the population infected with HIV is male,⁵⁰ infection rates among women are registering a steady increase.⁵¹ The ratio of HIV infection

between men and women narrowed from 4:1 in 2000 to 3:1 in 2004.⁵² Recent estimates suggest that the epidemic has also hit rural parts of the country.⁵³

India remains at a crossroads: by expanding and strengthening the response to HIV/AIDS, it may be able to avert widespread infections and possibly even reverse the epidemic among hard hit groups. Complacency and prevention fatigue are, however, very real threats. Any slackening in the response may result in the epidemic spreading widely enough to assume unmanageable proportions.

2. DRUG USE AND HIV/AIDS: LAW AND POLICY FRAMEWORK

2.1 Overview of the Legal System

India is a federal state with a unitary structure. There are twenty-nine states and six Union territories that comprise the Indian Union.⁵⁴ India is a democratic republic that follows a parliamentary system, including a cabinet-form of government styled on the Westminster model.⁵⁵

Legislative powers are conferred on the Parliament,⁵⁶ a bicameral entity with the Lok Sabha (the lower House) and the Rajya Sabha (the upper house).⁵⁷ Members of the Lok Sabha are the directly elected representatives of the people every five years.⁵⁸ Members of the Rajya Sabha are elected by members of the Lok Sabha, and a third retire every two years.⁵⁹

44 National AIDS Prevention and Control Policy (2002).

45 "HIV Prevalence in India is second highest in the world" (May 2005), available at http://www.rxpgnews.com/medicalnews/healthcare/india/article_1564.shtml.

46 National AIDS Control Organisation, available at <http://www.nacoonline.org/about.htm>.

47 NACO "An Overview of the Spread and Prevalence of HIV/AIDS in India", available at http://www.nacoonline.org/facts_overview.htm.

48 On the basis of the seroprevalence data, states have been classified as low (less than 1% in ANC sites and less than 5% in high risk group sites), moderate (less than 1% in ANC sites and more than 5% in high risk group sites) and high (more than 1% in ANC sites and more than 5% in high risk group sites).

49 Maharashtra, Tamil Nadu, Andhra Pradesh, Karnataka, Manipur and Nagaland. See NACO Overview above n47.

50 NACO Facts and Figures, see http://www.nacoonline.org/facts_reportapril.htm

51 World Bank Report on India, <http://lnweb18.worldbank.org/sar/sa.nsf/Countries/India/>. See also "HIV and AIDS in India" above n10.

52 NACO Facts and Figures, above n50.

53 See NACO overview above n47.

54 See The Economist "Country Briefings: India", available at www.economist.com/countries/India/profile.

55 Description of the Westminster System at http://www.biography.ms/Westminster_system.html

56 Constitution of India, Schedule VII. See also Pandey Chapter 21 Constitutional Law of India (Central Law Agency, 1999). Apart from the period of emergency, 1975 to 1977, elected representatives have governed India without interruption.

57 Article 79, Constitution of India.

58 Article 81(1). This may be sooner if Parliament is dissolved.

59 Article 83(1).

The President is the nominal head of government⁶⁰ and acts on the advice of the Council of Ministers (the Cabinet) of which the Prime Minister is the head.⁶¹ The Prime Minister is the de facto head of government.

At the state level, the Chief Minister is the equivalent to the Prime Minister,⁶² and the Governor is akin to the President.⁶³ The State Legislature, elected by citizens of its State, has lawmaking powers for that particular state.

The demarcation in lawmaking between Parliament and States is provided for in the Constitution, employing the doctrine of separation of powers.⁶⁴ The Parliament and the State Legislative Assemblies enact laws, the Executive implements these laws and the Judiciary interprets and enforces these laws and the Constitution. The Judiciary is the main arbiter.⁶⁵

2.1.1 Constitution

India has a written Constitution that provides for all areas of governance.⁶⁶ The Preamble proclaims that the Constitution will secure to all its citizens justice, liberty and equality.⁶⁷

Fundamental rights,⁶⁸ set out in Chapter III of the Constitution, are enforceable but only against State entities.⁶⁹ Some Fundamental rights are available exclusively to citizens whereas others are available to all persons. Fundamental rights

to equality include equality before the law and equal protection of laws,⁷⁰ prohibition of discrimination on grounds of religion, race, caste, sex or place of birth,⁷¹ equality of opportunity in matters of public employment⁷², and the abolition of untouchability⁷³ and titles.⁷⁴ Reservation in matters of public employment is specifically provided for historically backward classes.⁷⁵

No person's liberty or life can be deprived except in accordance with procedure established under law.⁷⁶ The Supreme Court has interpreted this provision, couched in negative language, expansively to encompass positive rights including health. Read with Article 14, this provision has been interpreted to be akin to the due process clause in the United States Constitution.

Fundamental freedoms guaranteed include the freedom to speech and expression,⁷⁷ to assemble peaceably without arms,⁷⁸ to form associations or unions,⁷⁹ to move throughout the territory of India,⁸⁰ to reside and settle in any part of the territory of India⁸¹ and to practice any profession, or to carry out any occupation, trade or business.⁸² Furthermore, all persons are equally entitled to freedom of conscience and the right to freely profess, practice and

60 Article 54. See also Pandey above n56 at 368-9.

61 Article 74, Constitution of India.

62 Article 164.

63 Article 170(1).

64 Pandey above n56 in chapter 29.

65 The demarcation in law making between Parliament and the States is provided in the Seventh Schedule and the three lists that go with it. Areas of law specified in list 1 are exclusively the preserve of the Union, list II the preserve of the States, and list III contains the concurrent list permitting both Parliament and the States to legislate upon.

66 The Indian Constitution is the longest Constitution in the world.

67 Constitution of India, Preamble.

68 Chapter III.

69 Article 12. This is in contrast to the Directive Principles contained in Chapter IV that are not enforceable at law; however they are supposed to be fundamental in the governance of the country.

70 Article 14, available to non-citizens also.

71 Article 15, available only to citizens.

72 Article 16, available only to citizens. Article 14 to 16 incorporate the doctrine of classification and non-arbitrariness.

73 Article 17.

74 Article 18.

75 Article 16(4). Though originally meant for only Scheduled Castes and Tribes, it now also includes "other backward classes".

76 Article 21, available to non-citizens also.

77 Article 19(1)(a). All the rights in Articles 19 (1)(a) to (g) are available only to citizens. India has a huge and critical print and electronic media. The Supreme Court has interpreted the right to freedom of speech expansively. This freedom is guarded zealously, and the Supreme Court has not allowed encroachment upon this right.

78 Article 19(1)(b).

79 Article 19(1)(c).

80 Article 19(1)(d).

81 Article 19(1)(e).

82 Article 19(1)(g).

propagate religion.⁸³ However these freedoms are not absolute and are subject to specified reasonable restrictions.⁸⁴

Trafficking in human beings, begary and other forms of forced labour are constitutionally proscribed and are punishable as offences in accordance with law.⁸⁵

The Constitution sets out rights of persons accused of criminal offences. The right not to be convicted of an offence except for the violation of a law in force is guaranteed, as is the right not to be subjected to a penalty greater than prescribed in the law for the time being in force.⁸⁶ A right also exists against double jeopardy, that is, a person cannot be prosecuted and punished for the same offence more than once.⁸⁷ The Constitution provides that no person on arrest can be detained in custody without being informed of the grounds of his arrest, or denied the right to consult or be defended by a legal practitioner.⁸⁸ Every person who is arrested or detained is required to be produced before the nearest magistrate within 24 hours. However, the Constitution provides for preventive detention.⁸⁹ Also, no person can be compelled to be a witness against himself.⁹⁰

All fundamental rights are enforceable by approaching the Supreme Court directly, which itself is a fundamental right.⁹¹ It is important

to note that any law inconsistent with or in derogation of fundamental rights is void.⁹² Any person or a citizen, depending on the fundamental right invoked, can move either the High Courts or the Supreme Court of India seeking a declaration that a particular law is void. If the Courts find the law is void on the ground of violation of fundamental rights, then the law would have no force. Furthermore, the Supreme Court has held that even an amendment to the Constitution may be declared unconstitutional, if it violates the basic features or structure of the Constitution.⁹³

2.1.2 Courts

India is divided into states and districts. The judiciary comprises District and Sessions Courts, exercising civil and criminal jurisdiction respectively, special Courts, authorities and tribunals, the High Courts and the Supreme Court. At the district level, civil judges (junior and senior divisions) and the Court of District Judge, and in some cases the High Court entertain and decide original civil cases depending on the value of the civil suit. Depending on the offence and the punishment, criminal cases are heard either by the Courts of Magistrates or the Courts of Sessions. Statutorily prescribed Courts and Tribunals hear matters relating to tax, labour, services, family, consumer and other issues. Special Courts try major drug-related offences, while Courts of Magistrates try the petty offences.

The District (in civil matters) or Sessions Courts (in criminal matters), or the High Court of that State, hear appeals against orders of civil and criminal Courts. Each State has a High Court or one or more benches of the High Court. The High Courts⁹⁴ have regulatory and supervisory (both administrative

83 Articles 25, available to non-citizens also. Like the right to free speech, minority rights, whether based on religion or language, are also zealously guarded by the concerned minorities and protected by the Courts. Every religious denomination has the right to establish and maintain institution of religious and charitable purposes; to manage its own affairs of religion; to own and acquire property and administer property in accordance with law (Article 26). Moreover, there is the freedom to attend religious instruction or religious worship in educational institutions (Article 27).

84 Articles 19(2) to (6)

85 Article 23, available to non-citizens also.

86 Article 20(1). All the rights in Article 20 are available non-citizens also.

87 Article 20(2).

88 Article 22(1), All the rights in Article 22 are available non-citizens also.

89 Article 22(4).

90 Article 20(3).

91 Article 32.

92 Article 13. However, the expression "law" has been interpreted to exclude non-statutory personal law, i.e. law which is applicable to a persons on the basis of their religion.

93 Keshevananda Bharati v. State of Kerala, AIR 1963 SC 1461. This cannot be deleted even by the amending power in the Constitution.

94 Some of the High Courts exercise original jurisdiction in civil matters and in certain matters including those relating to admiralty, company law and matters specified in the Constitution.

and judicial) powers over subordinate civil and criminal Courts in their territorial jurisdiction. There are intra-Court appeals in the High Courts; otherwise appeals from the High Court lie to the Supreme Court. The Supreme Court has appellate jurisdiction from any High Court or any tribunal, Court or authority,⁹⁵ as well as original jurisdiction in relation to enforcement of fundamental rights⁹⁶ and disputes between states.⁹⁷ It also has advisory jurisdiction.⁹⁸ Decisions of the Supreme Court are binding throughout India.⁹⁹

The Courts enforce the Constitution, statutory law enacted by Parliament and state legislatures, common law, customary law¹⁰⁰ and personal law.¹⁰¹ The legal system in India follows a common law system. The primary procedural civil law is the Code of Civil Procedure (CCP). The primary criminal substantive law is the Indian Penal Code (IPC) while the primary procedural criminal law is the Code of Criminal Procedure (CCrP). The primary law of evidence is the Indian Evidence Act. These statutes were originally enacted during the colonial era and have been amended several times since independence.

The Supreme Court and High Courts of India have demonstrated considerable judicial activism as evidenced by jurisprudence evolved under Public Interest Litigation (PIL).¹⁰² PIL allows any person with a bona fide and sufficient interest in an issue to file a petition to vindicate fundamental and/or statutory rights.¹⁰³ Locus standi extends to persons filing on behalf of those who are unable to approach the Court on account of their poverty or vulnerability.¹⁰⁴

95 Article 136.

96 Article 32.

97 Article 131.

98 Article 143.

99 Article 142.

100 A practice that is shown to have been in existence in a local community from time immemorial, or at least 30 years, is enforceable at law.

101 Personal law is applicable to a person because of his or her own religion

102 Article 32 and Article 226. Pandey above n56 in chapter 17.

103 Ibid.

104 Ibid.

The PIL jurisdiction of the Courts is expansive and has resulted in the redressal of wrongs, most notably in cases where the statutory authorities have failed in their duties. Indeed, the Supreme Court has even taken up PILs suo moto and has focused on enhancing access to justice through new modes of communication.¹⁰⁵ PILs have significantly contributed to progressive law in India, most notably in areas of environment, the application of international law in the domestic context, and rights of marginalized communities.

2.2 Drug Use and HIV/AIDS Harm Reduction Law

2.2.1 General penal provisions

Abetment of the commission of an offence and criminal conspiracy are punishable¹⁰⁶ under the Indian Penal Code.¹⁰⁷ Both are substantive offences and may also be punishable under any other special or local law.¹⁰⁸ Common intention, though not a substantive offence, may also be attracted if a common intention exists to commit a substantive offence, and that offence is committed.¹⁰⁹

HIV/AIDS public education campaigns relating to drug use may be punishable as obscenity. Other penal provisions may also apply, such as the sale and distribution of 'obscene' material,¹¹⁰ printing of grossly indecent material,¹¹¹ sale of obscene objects to young persons¹¹² and obscene acts and songs.¹¹³

105 See *People's Union for Democratic Rights v. Union of India* AIR 1983 SC 339; *Bandhu Mukti Morcha v. Union of India* AIR 1984 SC 803; *M.C. Mehta v. Union of India* AIR 1987 SC 1087, wherein letters to the Court are treated as writ petitions so as to not deny easy access to disadvantaged persons.

106 Section 107 IPC defines abetment and section 109 IPC provides the punishment for it.

107 Section 120A IPC defines criminal conspiracy to mean an agreement between two or more persons to do or cause to be done an illegal act or an act, which is not illegal by illegal means. Punishment is provided for in Section 120B IPC.

108 Section 40 IPC.

109 Section 34 IPC.

110 Section 292 IPC prohibits sale, distribution, circulation, exhibition of obscene material, pamphlets, writings, etc.

111 Section 292A IPC.

112 Section 293 IPC imposes a higher punishment if such objects are offered to young persons.

113 Section 294 IPC.

2.2.2 Drug use

(a) Legislative history

The first statutory law that regulated drugs in India was the Opium Act, 1857.¹¹⁴ As the name suggests, it was enacted only in relation to opium. The background to the Act was the Second Opium War in 1856, which saw China resist efforts by English traders to push opium into its territory. The British sought to consolidate and bring cultivation of poppy and manufacture of opium under their control through various administrative measures, including the said legislation. The Act provided for the appointment of officers to supervise opium production and trade.¹¹⁵ It introduced a system of licensing for cultivation whereby poppy could be grown after obtaining a license from state appointed opium agents or officers.¹¹⁶ Fines were imposed against unlicensed cultivators.¹¹⁷ Non-payment of fine and repeat conviction was punishable with imprisonment.¹¹⁸ The Act did not regulate, much less proscribe, the possession, use or consumption of opium or any other drug.

It was only with the Opium Act, 1878 that, for the first time, possession of opium was prohibited and made into a statutory offence in addition to cultivation of poppy, transport, import and export, sale and warehousing of opium, except as permitted by rules.¹¹⁹ The Act extended and strengthened government control over all matters relating to poppy.¹²⁰ The Act imposed the burden on the accused to account for the opium in respect of which s/he was alleged to have committed an offence.¹²¹ It conferred investigative and enforcement powers on officers of Departments of Central Excise, Narcotics, Drugs Control, Customs and Revenue.¹²²

In 1930, the Dangerous Drugs Act¹²³ was enacted, which applied to coca leaves, hemp and their derivatives, and opium and its synthetic varieties.¹²⁴ It prohibited, controlled and regulated the cultivation, possession, manufacture, sale, internal traffic, and external dealings in dangerous drugs. Allowing premises to be used for any of the prohibited acts and abetment of prohibited acts were made specific offences.¹²⁵ Though possession of opium was prohibited, possession for personal consumption was exempt from penalties.¹²⁶

All the three acts – the Opium Acts of 1857 and 1878, and the Dangerous Drugs Act of 1930 – supplemented each other. All three were repealed by a comprehensive legislation, the Narcotic Drugs and Psychotropic Substances Act, 1985 (hereinafter NDPS Act). The statute has been amended twice – in 1989 and 2001.

(b) Nature and classification of prohibited substances

Narcotic substances are coca leaf, opium, poppy straw and includes all manufactured drugs.¹²⁷ Psychotropic substances are those specified in the Schedule to the Act.¹²⁸ Buprenorphine, commonly used for maintenance therapy, is specifically mentioned in the Schedule.

Precursor chemicals are those used in the production or manufacture of narcotic or psychotropic substances and declared in a Notification as "controlled substances".¹²⁹ Till date, the government has notified 5 substances as such:

- ◆ Acetic Anhydride
- ◆ N-acetylc anthranilic acid

114 The Opium Act, 1857 (Act No. 13 of 1857)

115 Section 3.

116 Section 8.

117 Section 10.

118 Sections 27 and 28.

119 Section 4, Opium Act, 1878.

120 Section 5, Opium Act, 1878.

121 Section 10, Opium Act, 1878.

122 Sections 14 and 15, Opium Act, 1857.

123 Dangerous Drugs Act, 1930 (2 of 1930).

124 Section 2(h).

125 Dangerous Drugs Act, 1930.

126 Section 4(1)(b).

127 Section 2(xiv) NDPS Act.

128 Section 2(xxiii).

129 Section 2 (viid).

- ◆ Anthranilic acid
- ◆ Ephedrine
- ◆ Psuedoephedrine.¹³⁰

(c) *Offences and penalties*

The NDPS prohibits the following activities in relation to narcotics and psychotropic substances:

- ◆ Cultivation¹³¹
- ◆ Gathering¹³²
- ◆ Production
- ◆ Manufacture
- ◆ Possession
- ◆ Sale
- ◆ Purchase
- ◆ Transport
- ◆ Warehouse
- ◆ Use
- ◆ Consumption
- ◆ Import and Export Inter-state
- ◆ Import into and Export out of India
- ◆ Transship,¹³³ except for medical or scientific purposes and in the manner and to the extent provided for in the Act and the Rules under it¹³⁴
- ◆ Conversion, transfer, concealment, disguise, acquisition, possession of any property knowing that property is derived from an offence under the Act¹³⁵
- ◆ Allowing premises to be used for the commission of an offence¹³⁶
- ◆ Financing illicit traffic and harbouring offenders¹³⁷
- ◆ Attempt to commit an offence under the Act¹³⁸

- ◆ Abetment and Criminal Conspiracy to commit an offence under the Act¹³⁹
- ◆ Preparation in relation to offences of embezzlement, external dealings in drugs, illicit traffic and harbouring offenders involving commercial quantities of drugs.¹⁴⁰

Subject to the provisions of the Act and the Rules framed thereunder, the Central Government¹⁴¹ and the State Governments¹⁴² are specifically empowered to permit and regulate the activities in relation to narcotic and psychotropic substances that are otherwise prohibited under the NDPS Act. India grants permits for the lawful cultivation, manufacture, supply and export of narcotic and psychotropic substances. Licit drugs are, however, diverted to illicit markets.¹⁴³ Significantly, India is also a lawful producer of precursors such as acetic anhydride, which are diverted to manufacture heroin illicitly.¹⁴⁴

Punishments for the above mentioned offences depend not only the quantity of the drug but also on the type of substance involved. By the 2001 amendment, the terms "small quantity"¹⁴⁵ and "commercial quantity"¹⁴⁶ were added. Small quantity means a quantity lesser than the quantity specified in the Notification issued by the Government of India in that behalf, and commercial quantity means a quantity greater than the quantity specified in the Notification. There is also an intermediate range between the two. A Notification dated 19th October 2001 was issued in which the small and commercial quantities for every narcotics and psychotropic substance were specified. Offences in relation to small quantities are punishable with imprisonment up to six months or fine, or both. Penalties for

130 Interview with Mr. Subba Rao, Consultant, Project Associate, Regional Precursor Control Project for UNODC ROSA, New Delhi (25 January 2005).

131 Sections 8(a) and (b) NDPS Act.

132 Section 8(a).

133 Section 8(c) NDPS Act.

134 Section 8.

135 Section 8A.

136 Section 25.

137 Section 27A.

138 Section 28.

139 Section 29.

140 Section 30.

141 Section 9.

142 Section 10.

143 See UNODC "Country Profile: India", available at <http://www.unodc.org/india/en/938.html>.

144 Ibid.

145 Section 2(xxiii) NDPS Act

146 Section 2(viia).

offences involving greater quantities are graded hierarchically. Offences involving intermediate quantities result in imprisonment ranging from 2 to 10 years and fine of up to Rs 1 Lakh while drugs found in commercial quantities attract punishments ranging from 10 to 20 years in prison and a fine between Rs 1 and 2 lakh.¹⁴⁷

Repeat convictions attract enhanced punishment.¹⁴⁸ The death penalty is provided for a person who has previously been convicted of certain offences relating to embezzlement, external dealings, financing illicit trafficking and harbouring of offenders (including attempt to commit, abetment, criminal conspiracy) involving commercial quantities and is subsequently convicted of offences relating to production, manufacture, possession, transportation, import into and export out of India or transshipment involving certain quantity of specified drugs or financing any of those activities.¹⁴⁹

Use, consumption and possession

Use, consumption and possession of narcotic and psychotropic substances are punishable under the NDPS Act. The Act was amended in 1989 and thereafter in 2001. These amendments brought about important changes in respect to drug use and consumption.

Under the principal Act of 1985, a person found in possession of illicit substances in small quantities, if such possession is proven to have been intended for personal consumption, was liable for punishment with imprisonment for six months or one year.

The 1989 amendment proscribed "use", referring primarily to commercial activity and not personal consumption.¹⁵⁰ Secondly, by the amendment of 1989, the phrase, "small quantity . . . which is proved to have been intended for personal

consumption" was deleted from the section altogether. As a result, only if the prosecution is able to show actual consumption, can the accused be held liable for punishment.

A drug user found guilty of possession of a small quantity of a drug would be liable only for six months of imprisonment and if s/he is found guilty of consumption, s/he would be liable for either six months or one-year imprisonment depending on the substance consumed. Exceptionally, State Governments are specifically empowered to permit and regulate the possession of opium by an addict for personal consumption, if s/he is registered with the State Government and such consumption is medically prescribed.¹⁵¹

(d) Powers and procedures

The NDPS provides for search, entry, seizure and arrest to be made with a warrant issued by a Magistrate of the first class or a duly authorized Magistrate,¹⁵² or by an order of an officer of gazetted rank or any superior officer without a warrant on receiving information to be recorded in writing.¹⁵³ In exercise of powers conferred under the Act, investigating officers can:

- ◆ Enter and search any building, conveyance or place,¹⁵⁴
- ◆ In case of resistance, break open the door etc¹⁵⁵
- ◆ Seize illicit substances and confiscate any document or other material which may

151 Section 10(1)(a)(vi).

152 Section 41 NDPS Act. The power is exercisable under this provision in case he has reason to believe that a person has committed an offence punishable under the Act, or that a drug in respect of which an offence under the Act has been committed or any document or other article which may furnish evidence of commission of an offence under the Act or any illegally acquired property

153 Section 42(1). The power is exercisable under this provision on grounds akin to those in section 41. However there is a rider, namely that the officer must believe that a warrant cannot be obtained without giving the accused an opportunity to conceal evidence

154 Section 42(1)(a).

155 Section 42(1)(b).

147 Section 21 to 23.

148 Section 31.

149 Section 31A.

150 Section 2(xxviiiia).

furnish evidence of commission of an offence¹⁵⁶

- ◆ Detain, search and arrest persons suspected of committing an offence.¹⁵⁷

The person searched is required to be taken to the nearest Magistrate or an authorized officer. Further, the Magistrate or the authorized officer may discharge the person if s/he sees no grounds for the search. This procedural provision can be ignored by the arresting officer if s/he has reason to believe that the arrested person may part with illicit drugs found in her/his possession, and such reason is recorded. A female offender can only be searched by a female.¹⁵⁸ A person arrested must be informed of the grounds of her/his arrest, and taken to the officer in charge of the nearest police station or to the Magistrate who has issued the warrant for her/his arrest, as the case may be, without any delay, along with the articles seized.¹⁵⁹

Similar powers can be exercised with respect to offences committed in public places, which include hotels, restaurants and other places that are accessible to the public, or in transit¹⁶⁰ or in respect of a conveyance¹⁶¹ and in relation to coca plant, opium poppy and cannabis plant.¹⁶² Goods that cannot be confiscated are liable to attachment.¹⁶³

The goods which give rise to the offence include lawfully produced drugs found along with illicit drugs; utensils, receptacles, packages, coverings etc; animals and conveyances used;¹⁶⁴ goods used for the production of the illicit drugs;¹⁶⁵ proceeds from the sale of illicit drugs¹⁶⁶ are all liable to

confiscation. Whether or not a thing or an article seized is liable for confiscation is to be decided by the Court trying the offence.¹⁶⁷

In addition, property acquired by persons out of or by means of any income, earnings, or assets derived from or obtained from or attributable to the contravention of the provisions of the Act or traceable to such property is liable to forfeiture.¹⁶⁸

Provisions of the Criminal Procedure Code apply with respect to warrants, arrest, search and seizure.¹⁶⁹

Immunity is provided to governments and their officers against action taken in good faith.¹⁷⁰ However, officers guilty of conducting searches, seizures or arrests without reasonable grounds or vexatiously are liable to prosecution and punishment, as are persons who give false information willfully and maliciously and cause an arrest or search to be made.¹⁷¹ An officer who, having custody of an addict or any other person charged with an offence, acts willfully and in contravention of the Act is liable to rigorous punishment.¹⁷²

With respect to evidentiary requirements in trials, the NDPS Act creates a presumption of an offence against a person who fails to account satisfactorily for possession or the cultivation of:

1. Illicit or controlled substances
2. Any opium, poppy, cannabis or coca plant
3. Equipment, apparatus or utensil adapted for the manufacture of drugs
4. Any materials undergoing transformation and residue left of materials from which prohibited substances are prepared¹⁷³

156 Section 42(1)(c).

157 Section 42(1)(d).

158 Section 50.

159 Section 52.

160 Section 43.

161 Section 49.

162 Section 44.

163 Section 45.

164 Section 60.

165 Section 61.

166 Section 62.

167 Section 63

168 Chapter VA.

169 Section 50A.

170 Section 69.

171 Section 58.

172 Section 59.

173 Section 54.

In addition, standards relating to execution and admissibility of documentary evidence have been relaxed considerably compared to the Indian Evidence Act, to the advantage of the prosecution and against the accused.¹⁷⁴ Thus, statements made and signed before an officer empowered to take statements under the NDPS Act shall be relevant in certain circumstances.¹⁷⁵

(e) *Statutory structure for implementation*

Indian authorities regulate/control both licit and illicit manufacture, trade and distribution of narcotic and psychotropic substances.

The principal agency handling 'legal drugs' is the Central Bureau of Narcotics (CBN), headed by a Narcotics Commissioner, who exercises powers under section 5(2) of the NDPS Act. The main functions of the CBN are:

1. Licensing opium poppy cultivation¹⁷⁶
2. Procuring opium on behalf of the Government of India¹⁷⁷
3. Regulating opium and alkaloid processing factories that extract morphine, codeine etc. There are 2 such factories in India – one at Neemuch and the other at Ghazipur. Opium can only be manufactured by the government at these two factories.¹⁷⁸ The Chief Controller of Government Opium and Alkaloid Factories exercises control over these factories.¹⁷⁹
4. Distributing processed opium.

Legal opium is exported,¹⁸⁰ sold to pharmaceutical companies for production of medicinal drugs and supplied to state governments.¹⁸¹

With respect to illicit drugs, the Central and State governments are authorized to designate any agency for the enforcement of the NDPS Act. The Narcotics Control Bureau (NCB) was established under section 4 of the NDPS for co-ordinating anti-narcotics efforts all over the country.¹⁸² The Bureau acts as a nodal agency for intelligence and enforcement operations within the country, and for securing co-operation for narcotics control at international and bilateral levels.¹⁸³

Special Courts to try offences punishable with imprisonment for over three years have been set up under section 36 of the Act. Minor offences under the Act are tried by regular Courts.

(f) *Treatment and rehabilitation of users*

The term "addict" has been defined as a person who is dependent on any narcotic drug and psychotropic substances.¹⁸⁴

The Central Government has created a National Fund for the Control of Drug Abuse inter alia for

"identifying, treating and rehabilitating addicts, preventing drug abuse, educating public against drug abuse and supplying drugs to addicts where such supply is a medical necessity"

under Section 7A of the NDPS Act. No other information about the Fund or the deployment of resources for drug treatment was available.

The Act permits diversion of addicts from penal institutions into drug treatment and social reformation. Section 39 authorizes Courts to direct drug users convicted for illicit consumption under section 27 or any offence involving a small quantity to medical treatment facilities maintained or

174 Section 66.

175 Section 53A.

176 Rule 8, NDPS Rules

177 Rule 14.

178 Rule 31.

179 Section 2(d), NDPS Rules.

180 Rule 32.

181 Rule 33. See also interview with Mr. Subba Rao above n130.

182 Indian Agencies Fighting Economic Crimes, at <http://indiaimage.nic.in/ceib/default.htm>.

183 Narcotics Control Bureau "Annual Report of Economic Affairs", available at finmin.nic.in/the_ministry/dept_eco_affairs/budget/annual_report/9495rev7.PDF.

184 Section 2(i), NDPS Act

recognized by the Government or a local authority for de-addiction. The addict's entry into treatment is subject to the following conditions

- 1) S/he must be found guilty by the Court
- 2) An examination of age, character and antecedents of the case must be undertaken by the Court
- 3) The Court must be convinced of the expediency of such release
- 4) S/he must undertake to submit medical papers of treatment progress within a year by signing a bond (with or without sureties)
- 5) S/he must not commit any drug-related offence including taking of drugs¹⁸⁵

Drug users reporting successful completion of treatment after a year may be released by the Court upon an undertaking to desist from committing any offence under the Act for a period of three years. The Court may sentence a previously released addict who commits a drug-related crime.¹⁸⁶ No information was available on the application of this provision.

Drug users charged with illicit consumption or with offence involving small quantity of an illicit substance who volunteer to enter treatment for drug dependence at an agency authorized by the government are immune from prosecution. Immunity may be withdrawn if the addict fails to complete treatment.¹⁸⁷ While this provision facilitates treatment outside the penal system, the insistence on 'coming out clean' ignores the reality that recovery from drugs is complex and long-drawn and very often interspersed with episodes of relapse.

Under the Act, the Government may establish centres for identification, treatment, education, after-care rehabilitation and social re-integration

of addicts.¹⁸⁸ Such treatment centres and others approved by the Government are permitted to use prohibited substances for detoxifying addicts.¹⁸⁹ The Act enables non-government entities to set up drug treatment services. No information was available in this regard.

The government may supply drugs, otherwise prohibited, to drug users on medical grounds.¹⁹⁰ The Central¹⁹¹ and State¹⁹² Governments are authorized to frame rules to regulate such supplies. No information about the application of this provision could be ascertained.

Rules enacted under the Act allow licensed pharmacists to supply a narcotic or a psychotropic drug to foreigners carrying a medical prescription.¹⁹³ It is not understood why the provision applies to foreigners only and not to Indian citizens.

The NDPS Act clearly provides for treatment of drug-dependent offenders. However, medical assistance is routed through the criminal justice system that carries with it stigma and severe social disablement. Another drawback is that medical treatment, though not defined under the statute, has traditionally been read with de-toxification or de-addiction and given a restrictive meaning.

(g) Juveniles using drugs

Children¹⁹⁴ found consuming, possessing or engaging in other drug-related crimes are triable by a Juvenile Justice Board set up under the Juvenile Justice (Care and Protection) Act¹⁹⁵ that lays down procedures for child-friendly adjudication. Such boards comprise judicial officers trained in child

185 Section 39 (1).

186 Section 39(2).

187 Section 64A.

188 Section 71.

189 Rule 67A(a)(iii), NDPS Rules

190 Section 71, NDPS Act.

191 Section 76(2)(e).

192 Section 78(2)(a).

193 Rule 67A(c), NDPS Rules.

194 Section 2(k), Juvenile Justice (Care and Protection) Act, 2000 defines child as a person who has not completed the age of 18.

195 Juvenile Justice (Care and Protection) Act, 2000 [Act No. 56 of 2000] Hereinafter JJ Act.

psychology as also social workers,¹⁹⁶ ostensibly to deal with juveniles in conflict with law sensitively. Further, child offenders can be apprehended by Special Juvenile Police, namely officers trained to handle juveniles.¹⁹⁷ Further, juvenile delinquents cannot be detained with adults and can only be housed in Observation Homes (for temporary stay)¹⁹⁸ or Special Homes (for long term stay and rehabilitation).¹⁹⁹ Among other child-friendly measures, the Act encourages release of children on bail²⁰⁰ and forbids judicial officers from awarding death penalty or life imprisonment.²⁰¹

The Act proscribes the offering or administering of a narcotic drug or psychotropic substance to a child, except with a medical prescription or in case of sickness.²⁰² It provides for referral of drug-dependent children to an asylum, mental hospital, treatment centre for addicts or a place of safety.²⁰³ Children requiring prolonged treatment or suffering from TB, STDs, Hepatitis B and other such diseases are to be dealt separately through specialized referral services or under relevant laws.²⁰⁴

2.3 Drug Use and HIV/AIDS Harm Reduction Policy

2.3.1 Drug use

The government of India has responded to drug abuse through demand and supply reduction strategies. The Ministry of Social Justice and Empowerment (MSJE) is the principal agency responsible for drug demand reduction operations. Demand reduction concentrates on prevention and rehabilitation through awareness generation, counselling, detoxification and post-treatment services.²⁰⁵ Implementation is through non-

government organizations²⁰⁶ that are funded by the MSJE under the scheme for prevention of alcoholism and substance (drugs) abuse.²⁰⁷

Supply reduction is within the domain of enforcement agencies, whose operations are guided by the NDPS Act and the Rules framed thereunder. The Central Bureau of Narcotics oversees cultivation, processing, manufacture and distribution of licit opium. Agencies responsible for interdiction of illicit drugs are – Police, Customs, Central and State Excise departments, Central Bureau of Investigation (CBI), Directorate of Revenue (DRI, DGRI) and the Narcotics Control Bureau (NCB). While some of these are under the Ministry of Home Affairs, others are departments within the Ministry of Finance.²⁰⁸

The policy response to drug use, as evidenced by MSJE sponsored programs and law enforcement, has remained unchanged for the last two decades. It has been pointed out that the policy has not kept pace with emerging problems of injecting drug use and HIV/AIDS.²⁰⁹

2.3.2 HIV/AIDS

The policy framework for HIV/AIDS has evolved with the progression of the epidemic in India. In 1986, shortly after the detection of the first case of HIV/AIDS, the Government of India constituted a National AIDS Committee. A year later, the Ministry of Health and Family Welfare (MOHFW) launched a National AIDS Control Programme. In 1989, the WHO provided support for a medium-term plan for HIV prevention and control in the states most affected, namely Maharashtra, Tamil Nadu, West Bengal, Manipur and the union territory of Delhi.

196 Section 4, JJ Act.

197 Under section 2(w).

198 Section 8.

199 Section 9.

200 Section 12.

201 Section 16.

202 Section 25.

203 Section 58.

204 Section 48.

205 Ministry of Social Justice and Empowerment, Government of India "National Initiative for Drug Demand Reduction"

206 According to Ministry sources, there are about 450 centres all over the country that cater to 400,000 addicts annually. Ibid.

207 UNODC, Regional Office for South Asia and Ministry of Social Justice and Empowerment, Government of India "Inventory of Programs and Schemes to facilitate rehabilitation of drug and alcohol dependents" Resource Book (June 2004).

208 Interview with Mr. Subba Rao above n130.

209 UNAIDS and UNODCCP Task Force on Drug Use and HIV Vulnerability "Drug Use and HIV Vulnerability Policy Research Study in Asia" (October 2000).

In 1992, the National AIDS Control Organisation (NACO) was set up exclusively for implementing the AIDS control programme.²¹⁰

Between 1992 and 1999, NACO concentrated on promoting awareness about HIV/AIDS, improving blood safety and controlling sexually transmitted infections (STIs) in what was referred to as Phase I of the World Bank-sponsored National AIDS Control Programme (NACP). Simultaneously, capacity was created at the state level to implement HIV/AIDS prevention and control programs by setting up State AIDS Control Cells. Developing a sentinel surveillance system for tracking the progression of the epidemic was also accorded priority under Phase I of the NACP.²¹¹ In 1997, a Draft National AIDS Control Policy was floated laying down the strategic framework for halting the spread of the HIV/AIDS epidemic.

In 1999, the NACP entered its second phase, which will continue until 2006. Besides the World Bank, the NACP II received additional financial resources from multilateral agencies, with DFID and USAID being the major donors. More recently, private donors have stepped in to complement the government's AIDS prevention efforts.²¹² Key elements of programming under NACP II are: surveillance, prevention for those at risk, and treatment and care for persons infected with HIV. NACP II has seen further expansion and decentralization with the establishment of 38 autonomous State AIDS Control Societies for planning and executing local programmes within the framework laid down by NACO/ Union government. A large number of NGOs and CBOs are involved in various aspects of project implementation.

In April 2002, the Union Cabinet approved a blueprint for HIV/AIDS programming in the country as contained in the National AIDS Prevention and Control Policy (NAPCP). The policy accepts a rights-based approach to public health and states: "Government recognises that without the protection of human rights of people who are vulnerable and afflicted with HIV/AIDS, the response remains incomplete."²¹³ The NAPCP enlists separate prevention strategies for groups at higher risk and the general population. Aggressive IEC campaigning, blood safety and voluntary counselling and testing are to be promoted among the general population for AIDS prevention. The policy proposes to reach core groups, namely those considered at higher risk of contracting and transmitting HIV/AIDS with protection measures through 'targeted interventions'. The objective of these interventions is to restrict HIV transmission by controlling STDs and providing information and products like condoms for safer practices. Sex workers, MSM and IDUs are recognized as "high risk groups" or core groups universally, while truck drivers, migrant workers and children living in urban poverty are to be prioritized for prevention services depending on the local context.²¹⁴ The Government has announced over 20 guidelines²¹⁵ for operationalisation of plans and programs²¹⁶ set out under the NAPCP.

The policy directive for reducing transmission of HIV/AIDS among IDU and their partners is unambiguously one of harm reduction. The NAPCP notes the effectiveness of harm reduction measures such as health education, provision of sterile needles and bleach in containing HIV/AIDS. It encourages NGOs working in the field of drug demand reduction to initiate harm minimization

210 Information on NACO homepage, available at <http://www.naonline.org/about.htm>

211 For information about NACO, see http://www.naonline.org/abt_phase1.htm.

212 The Bill and Melinda Gates Foundation alone has committed US\$ 200 million to prevent the spread of HIV/AIDS in India. See <http://www.gatesfoundation.org/GlobalHealth/HIVAIDSTB/HIVAIDS/IndiaAIDSinitiative/default.htm>.

213 Ministry of Health and Family Welfare, National AIDS Control Organisation, Government of India "National AIDS Prevention and Control Policy", available at http://www.naonline.org/prog_policy.htm

214 http://www.naonline.org/prg_sche_targetint.htm.

215 For a complete list of NACO guidelines, see http://www.naonline.org/prog_guidelines.htm.

216 For NACO programs, see <http://www.naonline.org/program.htm>.

services including NSEPs.²¹⁷ Significantly, the guidelines for costing targeted interventions for IDUs budgets not only for needles and syringes but also for oral drug substitution.²¹⁸ Further, the policy guidelines recommend peer engagement and outreach as means to contact IDUs and influence behaviours.²¹⁹

Besides provision of tangible inputs like condoms and clean needles, the guidelines lay emphasis on creating conditions that are conducive for changing unsafe practices. The NAPCP itself views criminal laws that are inconsistent with the rights of vulnerable groups as impediments to AIDS prevention programs and call on the government to review the same.²²⁰

The Government of India has unambiguously and undisputedly accepted harm reduction among vulnerable groups as a core strategy in its anti-AIDS efforts.

3. DRUG USE AND HIV/AIDS HARM REDUCTION PRACTICES

3.1 Prevention

3.1.1 Drug Use

The MSJE is the nodal agency for drug demand reduction, which includes preventing the consumption of drugs and alcohol. MSJE provides financial assistance to NGOs for carrying out prevention work. The approach to drug abuse prevention has been one of caution and alarm, warning the public about the negative consequences of alcohol and drug addiction.²²¹ Messages/hoardings showing ill effects of alcohol

and advising people to stay away from drugs are common.

In addition to targeting the general public, attempts have been made to make the youth aware of harms associated with drugs.²²² According to secondary sources, the Government plans to integrate information on drug abuse in the school curriculum to augment existing counselling and awareness programs carried out by NGOs.²²³ Drug prevention and education has also been directed at the workforce. Abuse prevention programs at the workplace have reportedly been successful in involving workers and their families in anti-drug campaigns.²²⁴

The MSJE has received support from UN agencies, primarily the UNODC and ILO, in planning and executing various projects through community driven structures. Notable among these are – “Developing Community Drug Rehabilitation and Workplace Prevention Programs”, “Community wide demand reduction in India” and Community Wide Demand Reduction in North-Eastern States of India.”²²⁵ The National Centre for Drug Abuse Prevention (NCDAP) set up within the MSJE has emerged as an apex training and research body in the field of substance dependence.²²⁶ To build and expand local capacity to address drug related problems, eight Regional Resource Training Centres (RRTCs) have been established.

The style and substance of drug prevention programs has remained unchanged for over two decades. The impact of fear-based messages on the incidence of drug use has not been evaluated. Further, drug use prevention programs have not

217 NAPCP above n213.

218 NACO, MOHFW, Government of India “Costing Guidelines for Targeted Interventions” (November 2004), available at http://www.nacoonline.org/prog_guidelines.htm.

219 http://www.nacoonline.org/prog_guidelines.htm

220 NAPCP above n213.

221 Social Justice Forum “Drug Demand Reduction and Preventative Policies: Government of India’s Approach”, available at <http://socialjustice.nic.in/social/drugdemand.htm>.

222 Ibid

223 United Nations, International Narcotics Control Board (INCB) Report “Analysis of the world situation: South Asia” E/INCB/2004/I (2004) at 61.

224 ILO “Developing Community Drug Rehabilitation and Workplace Prevention Programmes” (2000), available at <http://www.ilo.org/public/english/region/asro/newdelhi/drugreha.htm>.

225 UNODC Regional Projects (2005), see <http://www.unodc.org/india/en/projects.html>.

226 “Drug Demand Reduction and Preventative Policies: Government of India’s Approach” above n221.

been modified to address the changing nature of drug use including the shift to pharmaceutical drugs, growing practice of injecting and associated health concerns like HIV/AIDS.

3.1.2 HIV/AIDS

(a) *Information education and communication/ behavior change communication*

Communication has been the mainstay of AIDS prevention programming in India. NACO and its counterparts at the state level are responsible for designing and disseminating IEC on HIV/AIDS. NACO has utilized both print and electronic and outdoor media among other communication and advocacy modes for IEC.²²⁷ Some private agencies have also launched HIV information campaigns.²²⁸ Given the geographical expanse and linguistic diversity, local organizations have played a crucial role in developing and disseminating AIDS prevention messages.

Besides awareness drives aimed at the general public, NACO also works with NGOs to run IEC programs for specific populations. The School AIDS Education Programme and the University Talk AIDS Programme are attempts to make young persons aware of the risk of HIV/AIDS.²²⁹ Health surveys indicate that though awareness about HIV/AIDS has gone up considerably, increased information has not resulted in adoption of safer practices.²³⁰ Health groups have noted that existing IEC and prevention messages have not effectively

reached women, particularly those living in rural areas.²³¹

For a long time, messages on HIV/AIDS prevention sought to invoke "fear" about the "dreaded disease".²³² Further still, messages were shrouded in shame and carried a strong moral overtone that, according to critics, resulted in an impression that HIV only inflicts 'depraved groups' like sex workers and not the ordinary person.²³³ In a review of IEC programming, NACO itself has noted that fear and blame-based IEC may have aggravated stigma and failed to create a realistic self-risk perception.²³⁴ Neutral messages on modes of HIV transmission and prevention have been criticized for being 'too clinical' and not addressing other aspects of sexual behaviour such as pleasure, power, gender and sexuality that have a bearing on risk and safety.²³⁵

While BCC is a component of targeted interventions under the NAPCP, educational material on IDU harm reduction has either not been developed or is inadequate.²³⁶ Existing IEC material on HIV/AIDS addresses injection safety only in the context of medical settings.²³⁷ Field workers in IDU harm reduction projects have felt the need to inform clients, in a clear and candid manner, about ways to inject drugs safely,²³⁸ though, legally, such material may be construed as abetting the offence of illicit drug use.

227 NACO, MOHFW, Government of India, "National IEC/BCC Strategic Framework for HIV/AIDS Programme" (2004), available at http://www.nacoonline.org/prog_guidelines.htm.

228 Population Services International (PSI), a Washington based non-profit agency, having HIV/AIDS prevention projects in several Indian states including Maharashtra, launched a massive communications initiative on HIV prevention in Mumbai in 2002-2003, which popularly became known as the 'Balbir Pasha campaign'. For details, see <http://www.psi.org/resources/pubs/balbir-pasha.pdf>.

229 NACO "Programs: Information, Education, Communication and Social Mobilisation", available at http://www.nacoonline.org/prog_iec.htm.

230 NACO Strategic Framework for HIV/AIDS above n227.

231 Pallikadavath and Stones "HIV/AIDS in India: What women know about it and what is the impact in rural areas" (Powerpoint presentation, Opportunities and Choices Programme, Centre for AIDS Research), available at <http://www.aids.soton.ac.uk/documents/SasWill-present.pt>.

232 A common site at public places was a hoarding or billboard reading "AIDS kills" and featuring an emaciated /skeletal patient.

233 See "Comment on India's AIDS Control Programme" at <http://www.genderhealth.org/pubs/AminIndiasAIDSControlProgrammeJul2003.pdf>.

234 NACO Strategic Framework for HIV/AIDS above n227.

235 See Comment on India's AIDS Control Programme above n233.

236 Interview with Enisha Sarin, Co-ordinator, John Hopkins – SHARAN Project, New Delhi.(December 2004)

237 A pamphlet on injection safety produced by the Delhi State AIDS Control Society, the local government agency overseeing HIV/AIDS interventions, advises use of disposable syringes in medical set-ups only. Such information is of little, if any value to a street IDU.

238 Interview with Vijay Kumar Gupta, HIV/AIDS Counsellor, SHARAN, New Delhi.(December 2004)

(b) *condom promotion*

Prior to the onset of the HIV/AIDS epidemic, condoms were one of the several contraceptive measures under the government's family planning initiative. However, condoms remained unpopular among married couples, the target of family planning programs. In the 1990s, condoms gained use in contexts outside marriage after being recognized as a practical and effective way to prevent sexual transmission of HIV/AIDS under the NACP. The objective of NACO's condom programming is "to ensure easy access to good quality, affordable and acceptable condoms to promote safe sex encounters."²³⁹

In India, condoms are available through three channels: commercial sale, social marketing at subsidized rates and free supplies. The government is responsible for monitoring quality,²⁴⁰ in addition to the task of promoting condoms for averting pregnancies, STDs and HIV infection. NGOs funded by NACO or SACS for targeted interventions with groups at high risk of HIV/AIDS including sex workers, MSM and IDUs undertake specific activities to convince clients to use condoms.²⁴¹ Yet, harm reduction project staff report poor demand for and uptake of condoms among IDUs.²⁴²

Despite official endorsement, condom promotion has not remained free from controversy both within and outside government circles.²⁴³ In late 2002, television spots on condom use and condom advertisements were pulled off air following objections by the then Health Minister, who insisted that promotion of safe sex, was "contrary to traditional Indian values".²⁴⁴ Since, the national programme for HIV prevention

has been made "holistic" – by laying "equal" emphasis on abstinence and monogamy along with condom use.

Condom promotion is not only imperiled by conservative thought and influence in India. The law as well as those enforcing it poses barriers to HIV prevention work among "outlawed" communities, including sex workers and MSM. In 2001, in Lucknow, AIDS educators supplying condoms to MSM as part of a male sexual health promotion project were arrested and jailed for "promoting homosexuality".²⁴⁵ Between 2002 and 2003, a successful condom promotion project in the red light area of Surat, Gujarat closed down because of stringent enforcement of the anti-prostitution law.²⁴⁶ The contradiction between criminal laws and health policies become obvious when seen in the context of condom promotion efforts among legally marginalized communities in India.²⁴⁷

(c) *Treatment for Sexually Transmitted Infections (STIs)*

The higher incidence of HIV infection among STI patients led the government to integrate the National STD Control Programme, established in 1946, with the National AIDS Control Programme in 1991.²⁴⁸ NACO has since concentrated on strengthening facilities for detection, management and treatment of STIs in both primary and tertiary health care settings. Training of health providers, surveillance, monitoring and research for STI control have also been accorded priority by NACO.

239 NACO "Condom Programming", available at www.naonline.org/program.htm.

240 Condoms are a scheduled drug under Schedule R of the Drugs and Cosmetics Act, 1940.

241 NACO Costing Guidelines for Targeted Interventions above n218.

242 Interview with Enisha Sarin above n236.

243 "Condom ads raise hackles of activists" Times of India, 13 January 2003.

244 "Minister wants condoms out of AIDS ad campaign", available at <http://www.infochangeindia.org>

245 The Lawyers Collective Legislating an epidemic: HIV/AIDS in India (Universal Law Publishing Co. Pvt Ltd, 2003).

246 T Tandon " Sex workers in Surat: Seeking Rights amidst wrongs?" From the Lawyers Collective Vol 18 No.10 (October 2003) at 28.

247 To illustrate, NGOs receiving government funding for targeted interventions with sex workers are required to work with pimps/madams and brothel owners in order to motivate clients to use condoms. All of these agents including the client are punishable under the Immoral Traffic (Prevention) Act, 1956.

248 NACO "Programs: STD Control", available at www.naonline.org/program.htm.

STI treatment is a vital component of targeted interventions with sex workers and other populations at risk. NGOs do not provide treatment; their role is to motivate clients to attend STI clinics in public hospitals. The government follows the WHO recommended syndromic management approach towards diagnosis as laboratory facilities are expensive.²⁴⁹

The Government itself notes that a very small proportion of STI patients seek treatment at public health facilities.²⁵⁰ STIs in women are rarely identified, let alone treated.²⁵¹ Uptake of services by 'core groups' is far from what is required for effective control of STIs and HIV infection. Social stigma, discriminatory attitude of services providers, inadequate screening and poor treatment compliance have been identified as some of the factors that impede successful STI prevention and control in India.

(d) Voluntary Counselling and Testing (VCT)

The Health bureaucracy in India rejected demands for mandatory HIV screening early on and instead, adopted voluntary and confidential testing for HIV/AIDS as the official approach to testing,²⁵² in accordance with prevailing international norms.²⁵³ VCT is well established within the National AIDS Policy and programme agendas. Elaborate guidelines have been drawn to operationalise and maintain quality standards at VCTs. These include, inter alia, providing pre- and post-test counselling, ensuring informed consent, protecting client confidentiality and offering referral services.²⁵⁴

Officially, 730 VCTs operate throughout the country, of which 650 are in the public health

sector - attached to tertiary and district hospitals, microbiology departments of medical colleges and blood banks.²⁵⁵ Another 80 are run within health facilities of state instrumentalities like the Railways, with accessibility limited to their workforce.²⁵⁶ Outside government, there are numerous private diagnostic facilities and pathology laboratories that conduct HIV testing without observing any official standards.

Notwithstanding formal policies espousing voluntary testing, HIV testing in health institutions is a matter of routine and is conducted without informed consent or even knowledge on the part of the individual being tested. Screening of patients at the pre-operative stage and women attending antenatal clinics is routine, unmindful of any national testing protocol.

Instances of sex workers arrested for soliciting in public, being ordered to undergo HIV testing by the police and/or magistracy are not uncommon. For IDUs, fear of public identification and discrimination in hospitals obstruct VCT access.²⁵⁷ Consequently, some NGOs have started offering counselling and testing facilities to IDUs on site.²⁵⁸

(e) Needle Syringe Exchange Programme (NSEP)

Acknowledging injecting drug use as a serious problem in some regions of India, the Government of India, in 2002, articulated its commitment to adopt appropriate strategies to prevent HIV transmission through injecting drug use.²⁵⁹ More specifically, the government advocates "appropriate health education, improvement in treatment services but in most practical terms, providing bleach powder, syringes and needles

249 Ibid.

250 Ibid.

251 See Comment on India's AIDS Control Programme above n233.

252 NACO "Guidelines on HIV Testing", available at www.nacoonline.org/guidelines/guideline_10.pdf

253 See Guideline 3: International Guidelines on HIV/AIDS and Human Rights.

254 NACO, MOHFW, GOI "Voluntary Counselling and Testing: Operational Guidelines" (2004), available at www.nacoonline.org/guidelines/vct_guidelines.pdf.

255 Ibid.

256 Personal Communication with Binod Mahanty, Technical Officer, WHO, New Delhi.

257 Interviews with staff at Sahai Trust, Chennai (January 2005) and Sharan, New Delhi (December 2004).

258 Interview with Enisha Sarin above n236.

259 NAPCP above n213.

for the safety of the individual."²⁶⁰ This response mirrored the Manipur State AIDS Policy of 1998, which advocated for harm reduction as an appropriate strategy to halting the transmission of HIV amongst drug users and their sexual or needle-sharing partners.²⁶¹ This state policy made specific mention of NSEP as a strategy to reduce the risk of spreading HIV/AIDS.²⁶²

The NAPCP acknowledges and reinforces realities seen across India, as NSEPs in India are reported to have started in the mid-90s. These NSEPs are currently running in Manipur, Delhi, Mumbai, Kolkata and Chennai.²⁶³ They are administered by NGOs with some financial support from the government.²⁶⁴ Although government supports NSEP, it is reported that actual involvement of government agencies like NACO and SACS in the programme is minimal.²⁶⁵

Across India, NSEPs employ peer education and outreach as primary strategies for delivering services, as opposed to utilisation of a clinical model.²⁶⁶ The mode of dispensing injection equipment, however, differs across organisations, as NSEPs may follow either the drop-in centre or mobile model. The drop-in model, endorsed by NACO, encourages IDUs to access the NSEP site, and is better suited to sites where IDUs tend to ghettoise at a place. The mobile model predominantly targets geographically scattered IDUs who may not visit a fixed site; therefore services are taken to locations where IDUs congregate. Mumbai-based Sankalp mapped sites where IDU were found and now conducts a mobile NSEP in a van that travels to these spots.²⁶⁷ On the other hand, SHARAN, a Delhi NGO, runs its NSEP at a drop-in centre in Yamuna

Ghat, an area where IDUs are found huddled in parks, on the streets and under a flyover.²⁶⁸ IDUs are encouraged to visit the centre, access NSEP and avail related health services.²⁶⁹ Here, outreach workers do not carry needles.²⁷⁰ SHARAN also follows a strict system of safe disposal of contaminated needles, an important feature of any NSEP.²⁷¹

Broadly, NSEPs in India adhere to the exchange model i.e. return of used injection equipment by IDUs for receiving a new one. Sankalp ensures exchange by marking needles.²⁷² Exceptions can and are made, and a needle is distributed to a client even without exchange.²⁷³ Distribution, if it occurs, is for other context-specific reasons. For instance, in Manipur, underground militant outfits assaulted drug users, resulting in IDUs fearing violence if they carried needles on their persons.²⁷⁴

NSEPs are integrated with health, HIV and drug treatment related services. Abscess management, dispensation of antibiotics, anti-diarrhoea medication, etc. are part of primary health care offered to IDUs.²⁷⁵ HIV/AIDS prevention information, counselling, condoms, care for STI and opportunistic infections, and VCT are available at some sites.²⁷⁶ NSEPs are also linked to drug-related services including detoxification, substitution and vocational training and rehabilitation.²⁷⁷ Additionally, some centres are able to provide nutritional support and basic sanitation like shaving and bathing facilities to promote health seeking.²⁷⁸ Some organisations like the Sahai Trust in Chennai

260 Ibid.

261 Manipur State AIDS Policy, see <http://imphaleast.nic.in/aidshome.htm>.

262 Ibid.

263 "Revisiting the Hidden Epidemic" above n4.

264 See SHARAN Project Information, available at <http://www.SHARAN.net/projects/DSACS.shtml>, See also "Revisiting the Hidden Epidemic" above n4 at 82, which states that government does not support these programs.

265 Cohen Science Vol 4 No. 23, available at www.sciencemag.org/cgi/content/full/304/5670/509.

266 "Revisiting the Hidden Epidemic" above n4 at 83.

267 Interview with Eldrid Tellis, Sankalp, Mumbai.(November 2004).

268 Ce'le'rier SWAPS "India: Life at the Outpost", available at <http://www.drugtext.org/library/articles/peddr0023.htm>.

269 See SHARAN Project Information above n265.

270 Interview with Vijay Kumar Gupta above n238.

271 Ibid.

272 Interview with Eldrid Tellis above n268.

273 Interview with Vijay Kumar Gupta above n238.

274 See SIDA "Injecting Drug Users and their Sexual Partners: An Outreach Intervention in Manipur" (June 2004).

275 Ce'le'rier above n269.

276 Interview with Lokesh, Programme Manager, Sahai Trust, Chennai.

277 Ce'le'rier above n269 at 83.

278 Interview with Enisha Sarin above n236.

work with sexual partners of drug users, primarily women.²⁷⁹

A feature common to many NSEPs is that staff members are former users. Their employment is based on the premise that an ex-injector or addict understands the process of 'getting clean', and can provide the necessary support.

Most importantly, in all the urban centres in which NSEP has existed, drug users accessed the services in large numbers, affirming the belief that IDUs will access and benefit from health services when they are offered. In Manipur, NGOs such as KRIPA and SASO reported enrolling 567 and 708 IDUs initially. In Delhi, the NSEP envisioned providing services to 1000 IDUs in one year.²⁸⁰ The programme exceeded its expectations by registering over 1700 IDUs at its NSEP site.²⁸¹ Over the course of the last year, the number of IDUs accessing the NSEP on a daily basis has also seen a rise.²⁸²

The impact of NSEP in reducing needle sharing and promoting safer behaviour among IDUs has not been comprehensively studied in the SAARC region.²⁸³ There are virtually no studies that examine causality between NSEP and reduction in unsafe drug injecting. Bangladesh is the only country to show data; that too through surveillance carried out among IDU. Yet, success stories from parts and pockets of the country have emerged. In Manipur, the "Rapid Intervention and Care Project" (RIAC), implemented by the SACS in partnership with community-based organisations to provide sterile needles and syringes, among other preventive services, is believed to have been instrumental in

the reduction of HIV prevalence rates among IDUs from 80.7% to 58% over a three-year period.²⁸⁴ In Kolkata, early introduction of and sustained support to harm reduction services like NSEP among IDUs has resulted in stabilising HIV prevalence at a low level among the target community for the last seven years.²⁸⁵

It is important to emphasize here that NSEPs across India have emerged with considerable commonalities and differences not only with respect to impact on drug users, but also vis-à-vis law enforcement, outreach workers and neighboring communities.

Sensitisation of and advocacy with law enforcement officials on harm reduction has played a significant role in the success of harm reduction work with IDUs across India. Sustained advocacy that began in Chennai seven years ago,²⁸⁶ particularly using the NAPCP, has resulted in an order issued by the Police Commissioner that outreach workers be allowed to carry on when conducting exchanges.²⁸⁷ This order states that NSEP are permitted due to the gravity of the public health problem.²⁸⁸ However, the legality of such a directive is open to question.

Delhi-based SHARAN also conducted police advocacy, albeit in a different manner. The

279 Interview with Lokesh above n276.

280 Records from SHARAN's targeted intervention using NSEP with funding from the Delhi State AIDS Control Society (January 2005) (On file with authors).

281 Ibid.

282 Ibid.

283 Presently, a study is underway in Delhi to evaluate a 3-component IDU intervention in Delhi as a collaborative project between SHARAN and the John Hopkins School University, Bloomberg School of Public Health, Department of International Health, USA. One of the components being studied is the NSEP vis-à-vis impact on HIV risk behaviours.

284 Rupachandra "Harm reduction among drug addicts: Manipur shows the way", available at <http://www.youandaids.org/Features/Manipur.asp>, quoting Dr.Khomdon Sigh Liasam, Project Director, Manipur AIDS Control Society.

285 Panda "Drug use among the urban poor in Kolkata: Behaviour and environment correlates of low HIV infection" National Medical Journal of India Vol. 15, No. 3 (2002).

286 Police intervention model programs are believed to be unique by workers. High levels of commitment by law enforcement officials who keep channels of communication open are believed to be the reason for the program's success. There are now specific individuals within organisations focusing exclusively on daily advocacy with law enforcement. Sahai Trust reports that there is no police harassment and that the program is dependent on the ongoing support of police. See Interview with Dr. Suresh and Lokesh above n276.

287 Ibid.

288 Ibid. Persons distributing illicit drugs, however, are still punishable under the order. These outreach workers also distribute condoms without police interference. All outreach workers carry an identity card and the Police Commissioner's letter.

NGO sent letters detailing the plan to open NSEP to the relevant police stations, and after the police acknowledged receipt, the NSEPs ran uninterrupted.²⁸⁹ To address the problem of arbitrary apprehension of IDUs by the police, clients enrolled in the programme were given registration cards, which met with mixed results: while some IDUs felt that the card protected them from arbitrary police questioning, others felt the card served as a marker of public identification that exacerbated harassment.²⁹⁰

Other cities have reported different experiences with law enforcement. In Kolkata, police tolerance and support to harm reduction programs with IDUs and sex workers has contributed to leveling off of HIV/AIDS incidence among core groups.²⁹¹ In Mumbai, Seva Dhan undertook advocacy to sensitise police to understand that IDUs are patients, not criminals.²⁹² Such a paradigm-shift from a criminal justice to public health understanding of injecting drug use has led to a decrease in police harassment.

It is reported that although top officials are sympathetic, lower cadre law enforcement require much sensitisation for IDUs to find an enabling environment.²⁹³ In the past, police are reported to have harassed outreach workers, posing an additional problem to the operation of NSEPs.²⁹⁴ NSEPs faced problems when outreach workers dispensed sterile needles to IDUs, as law enforcement officials imposed penalties on drug users for accessing needles, and outreach workers feared penalties for assisting because law

enforcement considered this act to be abetment.²⁹⁵ In Manipur, outreach workers were often picked up for possession of needles and syringes.²⁹⁶

The legality of NSEP under the NDPS Act remains an open question, as the provision of drug paraphernalia can be seen as facilitating the offence of drug consumption. Experts in the field view the ambiguity in the law as an obstacle to NSEP and feel that immunity is required for service providers, particularly outreach workers.²⁹⁷

In addition to the legal clarity that is required, community perception of drug users in general and IDUs in particular also needs to change before NSEPs can be widely accepted as a health promotion measure.²⁹⁸ In Manipur, the NGO SHALOM was initially controversial for its apparent encouragement of drug use and outreach workers bore the brunt of the community's wrath.²⁹⁹ Chennai-based Sahai Trust conducted extensive community advocacy, reporting a significant change in community response: community members now refer clients to the NSEP.³⁰⁰

Aside from harassment from law enforcement and community hostility in some places, there are other issues that plague NSEPs in India. Some feel that inadequate and often irregular funding of NSEPs has obstructed services, resulting in enrolled clients turning back to needle sharing.³⁰¹ Interventionists also feel that the coverage of existing NSEPs is insufficient to

289 The Lawyers Collective above n245.

290 Interview with Vijay Kumar Gupta above n238.

291 Panda above n286.

292 Interview with Veena Shukla, Assistant Programme Director, Seva Dhan, Mumbai.(November 2004)

293 Interview with Dr.Suresh, Sahai Trust, Chennai. Expansion of programs has proven difficult, as key police persons are sometimes transferred, requiring a fresh start to sensitisation.

294 In Chennai, the outreach workers were intimidated in the past. No charges were stated, and no cases booked under the NDPS Act or the IPC. Interview with Dr.Suresh above n294. See also Bhagat "HIV/AIDS in Manipur: in the 'state' of despair" Business Line (10 July 2002).

295 Interview with Dr.Suresh above n294.

296 The outreach worker was usually absolved by higher-level police officials, but such incidents create an environment of fear, inhibiting workers from conducting NSEP. See Rupachandra above n285.

297 See Interviews with Eldrid Tellis, Sankalp, and Dr. Suresh, Sahai Trust, Chennai.

298 Bhagat above n295.

299 Bhagat "Vicious Circle" (2 August 2002), available at <http://www.frontlineonnet.com/fl1915/19150420.htm>. See also Rupachandra above n285.

300 This NSEP reported positive results based on the credibility as a church-based organisation working with schools and doctors. Interview with Dr.Suresh above n294 and Lokesh above n277.

301 See Interview with Dr. Srivatsan, TTK Hospital Outreach, Chennai.(January 2005) See also Bhagat above n295.

make a dent on HIV incidence and prevalence rates among IDUs.³⁰²

(f) Oral drug substitution

Delivery of substitution medication to heroin injectors in India dates back to 1993 in a slum cluster in New Delhi,³⁰³ witness to serious drug abuse including injection of cocktail pharmaceutical drugs. Responding to the needs of a community grappling with addiction, SHARAN, an NGO, introduced a range of drug demand reduction services in 1993.³⁰⁴ Buprenorphine, which was hitherto available only in injectable form, was offered sublingually through outreach and street delivery.³⁰⁵ By 1995, a drop-in centre was established to provide drug- and HIV-related services in addition to substitution medication. The programme closed down in 1998 for various reasons including cessation of funding.³⁰⁶ Though no formal studies were done, community surveys after five years of the intervention showed drastic reduction in injecting drug use.³⁰⁷

Thereafter, oral substitution therapy was introduced in five cities – Delhi, Kolkata, Imphal, Mumbai and Chennai on a pilot basis.³⁰⁸ NGOs implementing the project catered to over 1,500 opiate users, using buprenorphine tablets. The programme ran until 2002 and was considered highly successful. The most significant outcome reported from the pilot sites was reduction in drug injecting – a finding supported by lower incidence of injection related abscesses and gangrenes among clients.³⁰⁹

After the project came to an end, clients were not able to sustain substitution therapy, which was expensive.³¹⁰ At that time, buprenorphine was not licensed as a pharmacological agent for detoxification and the programme is believed to have operated 'quasi-legally'.³¹¹

The inclusion of substitution medication within government funded IDU harm reduction services has been very recent.³¹² Presently, oral drug substitution using sublingual buprenorphine is available through NGO interventions in Delhi³¹³, Chennai³¹⁴, Kolkata³¹⁵ and Mumbai³¹⁶. Oral drug substitution is in the pipeline in Imphal, Manipur.³¹⁷ Of these, projects in Kolkata and Mumbai are supported through government funds. UNODC supported 5 small scale interventions in Delhi, Kolkata, Mizoram and Imphal in 2005 and proposes to increase this number in 2006. It is pertinent to note that substitution medication is not available to HIV-positive IDUs, who are on state sponsored anti-retroviral drug therapy.³¹⁸

All programs use sublingual buprenorphine, which is locally manufactured. In India, methadone and LAAM are not readily available.³¹⁹

Typically, buprenorphine tablets are crushed and administered to clients under direct supervision of medical or para-medical staff. In Delhi, clients at Yamuna Bazar Drop-In Centre come in every day for their dose.³²⁰ In Chennai, buprenorphine is delivered through direct observation treatment and the administration is supervised

302 Personal Communication with Greg Manning, SHARAN, New Delhi.

303 Nizamuddin Basti, a slum colony in South Delhi where heroin, cannabis and other drugs is easily available.

304 Personal Communication with Greg Manning above n302.

305 Dorabjee and Samson, SHARAN above n34.

306 Personal Communication with Greg Manning above n302.

307 Manning "An 'epidemic' of injecting drug use in Delhi" Powerpoint presentation (SHARAN) (On file with authors).

308 The project was financially supported by the European Commission. See Dorabjee and Samson "A multicentre rapid assessment of injecting drug use in India" International Journal of Drug Policy 11 (2000) 99-112. See also Interview with Dr.Suresh Kumar above n294.

309 Personal Communication with Luke Samson, SHARAN, New Delhi.

310 Interview with Dr. Suresh above n294.

311 Personal Communication with Luke Samson, SHARAN, New Delhi

312 NACO Costing Guidelines for Targeted Interventions above n218.

313 Notably through SHARAN.

314 Sahai Trust and TTK.

315 Calcutta Samaritans and CSIR.

316 Mukti Sadan. Government funding for another NGO, Sankalp, was reported to be in the pipeline. Personal Communication with Eldred Tellis above n268.

317 The Orchid Project, supported by Bill and Melinda Gates Foundation, has initiated IDU risk reduction in the North-east. One of the components is oral buprenorphine substitution. Personal Communication with L. Birenderjit, SASO, Imphal, Manipur.

318 Personal communication with L. Birenderjit ibid.

319 "Revisiting the Hidden Epidemic" above n4 at 82.

320 Interview with Vijay Kumar Gupta above n238.

in the community clinics by the clinic staff.³²¹ Prescription protocols are in various stages of development, including one by the UNODC.³²² Substitution is offered for a period of three to six months, after which clients are referred to detoxification/drug treatment facilities. Chennai-based TTK Hospital Outreach reports that nearly 100 users have quit and moved on to recovery programs after receiving substitution therapy.³²³ The programme reportedly serves as an entry point for other therapeutic interventions.³²⁴

Thus far, law enforcement or anti-narcotics agencies have not posed any major hurdles to oral drug substitution delivery. NGOs in Kolkata, Chennai and Mumbai reportedly maintain regular exchange with police officials to sensitise and solicit the latter's co-operation.³²⁵

It is important for legal purposes to distinguish between provision of buprenorphine as an oral drug substitute and its administration for detoxification of addicts.³²⁶ Buprenorphine is one of the many medications used to remove toxic effects of the drug being abused and relieve withdrawal symptoms under clinical supervision. Such use is permitted at government-recognized treatment centres under the NDPS Act.³²⁷ Administration of sublingual buprenorphine to opiate dependent users/injectors for purposes of managing dependence over a period of time, may, however, be questioned, unless medical treatment is defined broadly to include drug maintenance.

A gap observed in policy/programming is with respect to recognition or authorization of

NGOs providing substitution therapy to opiate dependent users. Typically, organizations running detoxification and drug treatment centres are granted approval by the MSJE. However, NGOs involved in delivery of drug substitution/maintenance, which has classically been viewed, as HIV harm reduction strategy and not as treatment for drug dependence, are not in contact with the MSJE, the nodal government agency for drug demand reduction. This divergence has thus far gone unnoticed but may spell trouble for harm reduction NGOs if the provisions pertaining to government recognition under the NDPS Act are scrupulously enforced.

3.2 Treatment

3.2.1 Drug Use

Government-sponsored treatment sites are run under MSJE, the focal point for drug demand reduction programs in India.³²⁸ The Ministry oversees the Scheme for Prohibition and Drug Abuse Prevention, which utilises a government/non-government partnership approach to provision of treatment.³²⁹

Under the scheme, voluntary organisations provide de-addiction/rehabilitation services, as well as other counselling, de-addiction and rehabilitation services.³³⁰ The government covers over 90% of the cost of such programs. The primary objective of running programs through voluntary organisations is to ensure that family and community support is central to the programme. These programs are based on the Narcotics Anonymous model utilised throughout India, emphasizing abstinence and recovery as key components.³³¹

321 Communication with Dr. M. Suresh Kumar above n295.

322 Personal Communication with Luke Samson, SHARAN, New Delhi

323 See Interview with Dr. Srivatsan, TTK Hospital Outreach, Chennai.

324 Ibid.

325 See Interview with Eldrid Tellis above n268.

326 For difference between detoxification and drug substitution, see UNODCCP "Demand Reduction – A Glossary of Terms" (New York, 2000).

327 Rule 67A(a)(iii) NDPS Rules.

328 "Drug Demand Reduction and Preventative Policies: Government of India's Approach" above n221.

329 Ibid.

330 Ibid.

331 See Dorabjee above n18. See also Delhi Narcotics Anonymous, <http://www.angelfire.com/in/nadelhi/index.html>.

There are reportedly 450 de-addiction centres being run across the country through voluntary organisations.³³² There are also 100 government-run centres designed to provide long-term, intensive medical attention to "hard-core" drug users requiring treatment.³³³ These programs are located within government hospitals, primary health centres, and other sites.³³⁴

The government has also set up specialised de-addiction centres under the National Drug Deaddiction Programme. The regional centre for Southern India, namely, the National Institute of Mental Health and Neurological Sciences (NIMHANS) de-addiction centre, offers inpatient and outpatient consultations, conducts outreach and workplace interventions.³³⁵ Similarly, Delhi-based All India Institute of Medical Sciences (AIIMS) runs outpatient services and community-based clinics.³³⁶ These programs are examples of community involvement within institutional models for de-addiction.

Access to drug treatment is difficult, as beds are limited in government centres.³³⁷ The cost for admission is also reported to be prohibitive.³³⁸ Admission can be voluntary or coercive, and involuntary treatment may result in admission to psychiatric hospitals.³³⁹ Additionally, a drug user's options are limited when a Court opts for imprisonment, as only a handful of jails across the country are equipped to treat substance dependence.³⁴⁰

The government utilises a psycho-social medical approach to drug use.³⁴¹ This entails, above and beyond familial and community involvement, using professionals from a wide array of disciplines. The patient undergoes detoxification for one to three weeks on an in-patient basis, and rehabilitation can last from one to six months.³⁴² The costs for medication can be prohibitive, and it is reported that this cost is often borne by the user. Relapse rates are considered to be as high as 80%.³⁴³

3.2.2 HIV/AIDS

In December 2003, the Government of India took a major step announcing its sponsorship of free anti-retroviral treatment (ART) in six states, with a target of 25,000 persons receiving treatment by 2005 and 100,000 by 2007.³⁴⁴ This programme, envisaged to scale-up gradually, heralded a significant shift towards a comprehensive HIV/AIDS strategy for India, including the essential components of both prevention and treatment. The government targeted the six high-prevalence states for provision of ART, including Tamil Nadu, Karnataka, Andhra Pradesh, Manipur, Nagaland, as well as the capital city of Delhi.³⁴⁵

The programme was launched on 1 April 2004, after medical professionals from 15 institutions underwent training.³⁴⁶ The treatment centres are integrated into government hospitals. The programme has now expanded to include 25 sites in various states.³⁴⁷ Presently, the government has provisioned for first-line regimens using fixed-dose combinations of Zidovudine, Lamivudine, and Stavudine, in conjunction with Nevirapine

332 Ministry of Social Justice and Empowerment, Government of India "National Initiative for Drug Demand Reduction" (BROCHURE) .

333 Ibid.

334 Ibid.

335 National Institute of Mental Health and Neurological Sciences Information page, www.nimhans.kar.nic.in/deaddiction/About.htm.

336 All India Institute of Medical Sciences Information, <http://www.aiims.ac.in/aiims/departments/spcentre/deadict/deadict.htm#OPD>.

337 "Revisiting the Hidden Epidemic" above n4 at 81-2.

338 Ibid.

339 Ibid.

340 UNODC, Ministry of Social Justice and Empowerment "Drug Abuse Among Prison Population – A Case Study of Tihar Jail" (2002).

341 Ministry of Social Justice and Empowerment, Government of India "National Initiative for Drug Demand Reduction" (BROCHURE).

342 "Revisiting the Hidden Epidemic" above n4 at p 81-2.

343 Ibid at 82. See Also Interview with Eldrid Tellis above n268.

344 NACO, MOHFW, Government of India, "Statewise List of VCT, ARVs, and PPTCT centres", available at http://www.naonline.org/directory_arv.htm. See Also MOHFW, Government of India, Lok Sabha "Unstarred Question No.3561 to be answered on 22nd December 2004: ARV Treatment".

345 NACO Statewise List of VCT, ARVs, and PPTCT centres above n345.

346 Ibid.

347 Ibid.

and Efavirenz.³⁴⁸ It is reported that Efavirenz, the only treatment option for IDUs coinfecting with HIV and Hepatitis C, is unavailable or inadequate at most sites.³⁴⁹

The programme has not come close to achieving its target of treating 25,000 persons by 2005: the number of persons receiving treatment by 2005 June was 8,000. The challenges facing these centres have been multiple, including a lack of testing equipment, inadequate infrastructure, and a paucity of first and second-line regimens of

medications.³⁵⁰ The government has also attributed slowdown of scale-up to possible concerns regarding patient adherence.³⁵¹

Universally, IDUs find it difficult to access basic health care. Medical staff often assume that drug injectors are HIV-positive and avoid treating patients. IDU access to the government-sponsored treatment for HIV also has been limited.³⁵²

348 NACO, MOHFW, Government of India, "National Guidelines for Implementation of Antiretroviral Therapy (ART)", available at http://www.nacoonline.org/prog_guidelines.htm.

349 See Personal Communication with Elango Ramachandra, Karnataka Network Positive People, Personal Communication with P. Kousalya, Positive Women's Network, Chennai noting that Hepatitis C medications are also unavailable across the country including Tamil Nadu, Manipur and Nagaland.

350 Personal Communication with L. Birenderjit, SASO, Imphal, Manipur. See posting on International Treatment Preparedness listserve, Ratan Singh, Manipur Network of Positive Persons (1 April 2005) See Personal Communication with Elango Ramachandra, above n350, Personal Communication with P. Kousalya above n350.

351 The Lawyers Collective HIV/AIDS Unit, Minutes of the Monthly Thursday Drop-In Meeting, "Government of India's Anti retroviral treatment (ART) Roll-Out Plan" Lawyers Collective HIV/AIDS Unit, Delhi Project Office (3rd February 2005).

352 Letter from Luke Samson, Director, Sharan to the Project Director, NACO pointing out the discrimination faced by IDUs from the Yamuna Ghat area at Lok Nayak Jai Prakash hospital, one of the designated ARV treatment centres in Delhi (23rd July 2003). (On file with authors).

III. COUNTRY ANALYSIS – (D) MALDIVES

Maldives, an archipelago, has a population of approximately 339,330,¹ primarily concentrated on 200 islands.² The country comprises Dravidian, African, Arab and Sinhalese ethnic populations, and is primarily Muslim by religion. The national language is Dhivehi. 40% of the country's population is classified as "rural poor". The literacy rate for adults is 97.2%.³

1. DRUG USE AND HIV/AIDS: RISKS AND VULNERABILITIES

1.1 Drug Use

The geographical location of Maldives places it as a conduit between Asia's main illicit opium producing areas, namely the Golden Triangle – Myanmar, Laos and Thailand – and the Golden Crescent – Afghanistan, Iran and Pakistan.⁴ All the same, Maldives is less impacted than other SAARC countries by drug trafficking.⁵ At the same time, the country's attractiveness as a tourist destination makes it susceptible to heavy drug sale and purchase. Maldives is not, however, a producer of illicit drugs, and the medicines manufacturing industry is virtually non-existent.⁶

Except for the use of opium for medicinal purposes historically, there is no evidence of other drug use in Maldives.⁷ The introduction of narcotic drugs in the 1970s is believed to coincide with tourism, which created conditions for increased interaction with the outside world.⁸ It is important to note, however, that tourists and Maldivian citizens are kept on separate islands in order to prevent "cultural contamination".⁹ The main drugs used in the Maldives are brown sugar, hashish oil and cannabinoids.¹⁰ Drug use is reported to have increased 40 times between 1977 and 1995.

The Rapid Situation Assessment of Drug Abuse in Maldives, 2003 (RSA) further states that drug users are predominantly male youth who have not attained a high level of education. This increase in drug use in Maldives occurred despite stringent drug laws and concerted efforts from governmental bodies.

1.2 Injecting Drug Use

The RSA notes that the drug scenario is assuming alarming proportions, but statistics show that injecting drug use is low.¹¹ Interestingly, the RSA indicates an increasing rate of injecting drug use, with 8% of those interviewed having tried injecting, and 33% having witnessed

1 CIA Factbook: Maldives, available at www.cia.gov/cia/publications/factbook/print/mv.html (July 2004).
2 Country Profile: Maldives, available at ippfnet.ippf.org/pub/IPPF_Regions/IPPF_CountryProfile.asp.
3 Human Development Report, available at hdr.undp.org/statistics/data/cty/cty_f_MDV.html.
4 Manoharan "Drug Trafficking in South Asia: A Profile" (Institute of Peace and Conflict Studies, 2003), available at http://www.ipcs.org/South_Asia_articles2.jsp?action=showViewandkValue=1122&country=1016&status=article&mod=a
5 Paolienlal Haokip "Drug Trafficking and Counter Measures in South Asia II" (Institute of Peace and Conflict Studies, 2003), available at <http://www.ipcs.org/whatsNewArticle11.jsp?action=showViewandkValue=1128&status=article&mod=b>.
6 WHOSEA "Country Health: Maldives", available at w3.whosea.org/cntryhealth/Maldives/Maldives.pdf.

7 Rapid Situation Assessment of Drug Abuse in Maldives (2003), available at www.mv.undp.org/docs/drug_report/drug.pdf.
8 Feedback received from the National Narcotics Control Bureau (NNCB) via email dated 30.1.2006 (On file with authors)
9 International Women's Rights Action Watch "Country Reports: Maldives", available at iwwraw.igc.org/publications/countries/Maldives.htm.
10 RSA and DDDR.
11 RSA above n7. The World Bank report suggests that IDU could rise because it is rising in the SAARC region and the changing socio-economic scenario and due to other variables.

injecting.¹² Furthermore, Drug Rehabilitation Officers have reported finding needles at the site of arrest.¹³ Such findings are supported by anecdotal evidence: government counselors/NGOs say their client interactions substantiate this information.¹⁴

1.3 Other Vulnerabilities

(a) Youth

Maldivian authorities are particularly concerned about the rise of drug use in youth. 35–50%¹⁵ of the Maldivian population falls between 16 and 35 years of age and 44% of the population is below 15 years of age.¹⁶ The age range of drug use initiation is reported as 10–27 years.¹⁷ The Report of the Ministry of Defense and National Security, on drug abuse cases from 1997–2001, shows the existence of a large number of drug users between 16 and 24 years.¹⁸ In the Maldives, the drug user community is small and tightly knit.

1.4 HIV/AIDS

(a) Sex work

The concept of "sex work" is very different in the Maldives and is not entirely based on the 'market model'.¹⁹ The RSA in 2003 reports that a high number of drug users interviewed had sex with sex workers.²⁰

Due to a freedom from inhibitions, Maldivians often take up multiple partners in their lifetime.²¹

High rates of sexual activity with sex workers and multiple sex partners increase vulnerability of this population to HIV.²²

According to some sources, sex is being traded for drugs within this community.²³ Injecting drug use is experimented with but has not yet become a trend, although some sources point to signs that injecting is increasing.

(b) Prevalence

HIV rates are low.²⁴ The first case of HIV was detected in 1991.²⁵ It is reported that only 11 persons of Maldivian origin were found to be HIV-positive between 1991 and 2000, whereas 85 foreigners were tested HIV-positive between 1995 and 2000.²⁶ According to the Department of Public Health (DPH), however, there are now a total of 13 Maldivian cases of HIV since 1992, and only 3 or 4 people are still alive.²⁷

Thus far, 139 "expatriates" or "foreigners" were diagnosed HIV-positive. Of these, 95% were reportedly Indians seeking jobs. The Health Report 2004 shows that 45,739 people were screened during the year 2003 and one Maldivian and 12 foreign nationals were found to be HIV-positive.²⁸ According to one source, no injecting drug user (IDU) has tested HIV-positive.²⁹

There are no reported cases of children with HIV/AIDS, and awareness is reported to be extremely high, with 97% of children being aware of HIV/AIDS.³⁰

12 RSA above n7.

13 Ibid.

14 Ibid. Interviews with NCB counselors, and interview Mr. Hussain Zamir, Founding Member, and other members of the Society for Social Services.

15 US Department of State "Country Profiles: Maldives" (2002), available at www.state.gov.

16 Maldives Census (2000), available at www.planning.gov.mv/publications/census2k/index_gal.htm

17 RSA above n7.

18 The Report of the Ministry of Defense and National Security.

19 See Interview with Aishath Shiham *ibid.*, and RSA above n7.

20 RSA above n7.

21 Ibid.

22 Ibid.

23 Ibid.

24 UNAIDS "HIV Rates: Maldives", available at http://hivinsite.ucsf.edu/pdf/UNAIDS/Maldives_en.pdf

25 Interview with DDG (Council Activity Manager) and Program Manager, National AIDS Program, Department of Public Health (October 2004).

26 RSA above n7.

27 Interview with DDG and Program Manager, National AIDS Program, Department of Public Health n377.

28 Ibid.

29 Interview with Mr. Hussain Zamir above n14.

30 See UNIFEM Report on Interview with Aishath Shiham, Childrens Bureau.

(c) Migration

There are several reasons postulated for the heightened vulnerability of Maldivians to HIV. The most oft-cited reason is the migration of Maldivians for education and business, particularly to high-prevalence regions harboring mobile populations.³¹ The Maldivian economy largely depends on tourism³² and the inflow of tourists is also believed to present risk factors.

Multiple partner sexual activity is common in Maldives although it is punishable by law.³³ It is interesting to note that data from 1995 revealed that 280 persons, or 29.7% of the population, were sentenced for offences related to sexual activity outside of marriage.³⁴ Although this figure includes persons of all ages, currently the majority of sex offenders are adolescents.³⁵ The RSA report states that 92% of Maldivians experienced sexual relations during their teenage years.³⁶

Sexual activity under the influence of drugs is recorded to be as high as 65%. Contraceptives remain unpopular in Maldives.³⁷

Population demographics are referenced for vulnerability analysis as well: a high proportion of young men are at risk due to sexual activity, drugs and poverty.³⁸

(d) Blood transfusion

Another risk factor amongst Maldivians is the extraordinarily high incidence of thalassaemia. One out of every six Maldivians is reported to be a thalassaemia carrier.³⁹ This hereditary blood

disorder requires frequent blood transfusions, a potential mode of HIV transmission. There are many thalassaemic children requiring monthly blood infusions, and securing both donors and treatment is a grave challenge. There is also a fear that accepting blood donations heightens risk for Maldivians because of 'window-period' and blood source considerations.⁴⁰

2. DRUG USE AND HIV/AIDS: LAW AND POLICY FRAMEWORK

2.1 Overview of the Legal Framework

The Maldives, formerly a protected colony under the British, gained independence in 1965.⁴¹ Since the Maldivian population is dispersed, the system of administration is extremely decentralized.⁴² The administrative units are titled "atolls", and each of the nineteen atolls is headed by a chief, who is appointed by the President.

Another aspect of the Maldivian state that needs to be noted is the unique nature of civil society.⁴³ Until last year, non-governmental organizations (NGOs) were not recognized under law.⁴⁴ Last year for the first time, a law was passed providing for the registration of NGOs, the imposition of conditions, and the approval of funding by the Home Ministry.⁴⁵ The concept of "civil society" itself is being redefined in Maldives.⁴⁶

31 Ibid.
32 Ibid.
33 RSA above n7.
34 Ibid.
35 Ibid.
36 Ibid.
37 Only 17% of the population is reported to use condoms, See WHO, UNAIDS "HIV/AIDS and STI Report" (2002).
38 WHO Annual Health Report: Maldives (2001 and 2004) at <http://w3.who.sea.org/ehp/chp-mal01.htm>.
39 See WHOSEA above n6.

40 Source declined to be named. Interestingly, thalassaemia carrier status is also thought to be lifesaving because carriers are resistant to malaria. One source described similar patterns in coastal areas of Sri Lanka, Kerala and non-coastal areas of Bangalore and north India.
41 Information available at www.maldivesculture.com/maldives_amnesty_report2003.html.
42 Country Profile above n2.
43 Interview with Mohamed Zuhair, CEO, Society for Health Education.
44 Ibid.
45 Ibid.
46 It is also illustrative to note that programmatically, in terms of international donor funding, only Maldivian NGOs are eligible. Therefore, public offices state that there are only 5-7 NGOs in all of the Maldives. Community-based organizations, located on the various atolls and islands, are believed to be "second rate", which

2.1.1 Constitution

In 1968, a new Constitution was adopted.⁴⁷ The current Constitution came into effect on 1 January 1998.⁴⁸ Under the new Constitution, Maldives was established as a democratic republic, founded on Islamic principles.

The Maldivian legal system is a combination of common law and the Shari'ah.⁴⁹ The structure of the legal system comprises the legislative, executive and judicial branches.⁵⁰ The legislative branch consists of the People's Majlis, the executive branch accords the President authority to render Islamic interpretations and the judicial branch follows the norms of English common law.⁵¹

The Shari'ah lays down all "civil laws and societal norms", which follow the Sunni Islamic tradition. The Shari'ah is integrated into the legal system, with civil law being subordinate to Shari'ah.⁵² Under the Constitution, law is defined as including the norms and provisions of Shari'ah.⁵³

The Constitution guarantees that all citizens are equal before and under the law, and provides for equal protection under the law for all citizens.⁵⁴ An accused has the right to defend himself in accordance with the Shari'ah, and he can obtain

the assistance of a lawyer.⁵⁵ However, assistance means advice and not appearance in a Court of law. An accused has to defend him/herself in Court.⁵⁶ The presumption of innocence is accorded to those accused of crimes.⁵⁷

Persons are protected against prolonged detention beyond seven days, and there is a prohibition of acts detrimental to the life, liberty, body, name, reputation and property of persons, except as provided by law.⁵⁸ Maldivian citizens are constitutionally protected from oppressive treatment, and have the right to appeal against such treatment.⁵⁹

Freedom of protected speech is restricted to the extent that it is necessary to protect the sovereignty of the Maldives, maintain the public order and protect the tenets of Islam.⁶⁰

2.1.2 Courts

Magistrates handle legal matters that arise on the islands. If a matter is serious, the Courts in Male, the twentieth administrative unit, hears the case. The Courts in Male include eight lower Courts and the High Court. Maldivian judges are appointed and removed by the President. Judges must be Muslim.

In September 1997, the government restructured the judicial system, with three types of lower Courts: Madani (Civil) Court, Jinaaee (Criminal) Court, and Aaelee (Family/ Juvenile) Court.⁶¹

2.1.3 Criminal justice system

Statutory law and the Shari'ah are read together.

is problematic in terms of civil society participation. Government organizations are considered to be NGOs. The crucial consequence of such classification is that governmental organizations thus capture funding intended for NGOs. Furthermore, it is believed that community-based movements cannot succeed in Maldives for other reasons, primarily because of a belief prevalent in the Maldives that only government programs are accompanied by a "guarantee". Implied and by experience, it is thought that community or NGO control of programs cannot succeed. See *Ibid.*

47 Presidency of the Maldives, <http://www.presidencymaldives.gov.mv/>

48 *Ibid.*

49 Haleem Mohamed "The Maldives Criminal Justice System: An Alternative Method for Punishment", available at www.unafei.or.jp/pdf/no61/ch15.pdf.

50 Article 4(1).

51 Article 4(2).

52 Country Reports Human Rights Practices: Maldives (2003), see politinfo.com/information/Human_Rights/countries.

53 Article 156, Constitution of Maldives.

54 Article 13.

55 Article 16.

56 Article 16.

57 Article 16.

58 Article 15.

59 Article 15.

60 Article 25.

61 Amnesty International "Country Reports: Maldives", available at <http://web.amnesty.org/library/eng-mdv/reports>.

2.2. Drug Use and HIV/AIDS Harm Reduction Law

2.2.1 Condoms

Use and access to contraception is subject to legal restrictions including prescription from a medical practitioner or community health worker.⁶² Officials confirm that condoms are exempt from such restrictions and are sold at all pharmacies.⁶³

2.2.3 Drug use

(a) *Legislative history on narcotics law 17/77*

The original Law on Narcotics⁶⁴ was enacted in 1977. However, it has been amended four times since then, reflecting the problems related to increasing drug consumption, and to be in consonance with the UN and SAARC narcotics conventions. The first amendment introduced two schedules demarcating "illegal drugs" and "medical drugs" for purposes of criminal culpability, in keeping with the UN and SAARC conventions. Distinctions were created in the first amendment for penalties between users and suppliers of illicit drugs. Specifically, it enhanced the penalty to life imprisonment for suppliers who manufacture, import, export or sell prohibited drugs.⁶⁵ The amendment also moved towards leniency for drugs users, providing for rehabilitation.

The second amendment was introduced in 2001, protecting confidentiality of drug users interviewed for the purpose of research. The third amendment, brought in 2002, made surveying, monitoring and working with drug users possible without the need to report back to them. The fourth amendment, made in 2003, raised the age of "minor" to 18

years from 16 years. These amendments created space for effective drug use interventions.

(b) *Classification of prohibited substances*

The classification of prohibited substances is found in the schedules to the law, categorized into "Illegal Drugs" and "Medical Drugs".

Illegal Drugs include cannabis, cocaine, heroin, buprenorphine and MDMA. Methadone, pethidine, morphine and codeine are classified as medical drugs.

In the context of harm reduction, it should be noted that buprenorphine is on the schedule of illegal drugs, whereas methadone and pethidine are on the schedule of medical drugs. Alcohol use is proscribed under the Shari'ah⁶⁶

(c) *Offences and penalties*

The "planting, production, import, export, selling, buying, giving, possession, with the intention to sell and being an accomplice in any such activity involving illegal drug" is punishable with life imprisonment.⁶⁷

The "import, export, production, planting" and the "dealing, giving, selling, possession, handling, or attempt to do any of these" in relation to any of the scheduled drugs which can be used for a medical purpose without the permission of the Ministry of Health and Welfare, is criminalized.⁶⁸ Being an accomplice to such a crime is also punishable.⁶⁹ For the latter category of activities, the requirement is more stringent: the Ministry of Health and Welfare must give written permission to authorize the activity.⁷⁰

62 Maldives abortion and reproductive health ;policy available at www.un.org/esa/population/publications/abortion/doc/maldives.doc. See also International Women's Rights Action Watch above n2.

63 Feedback received from Mr. Ahmed, National Narcotics Control Bureau (NNCB) via email dated 30.1.2006 (On file with authors)

64 No. 17/77.

65 Section 2 of Narcotics Law.

66 RSA above n7.

67 Section 2(a) and 2(c), Narcotics Law.

68 Section 3(a) and 3(b).

69 Section 3(a) and 3(b).

70 Section 3(b).

The use or possession of any illegal drug is penalized.⁷¹ If a person possesses less than one gram of an illegal drug, irrespective of the category of drug, it is considered possession for use.⁷² The punishment for such an offence (of possession or use of any illegal drug) is imprisonment, banishment or house arrest for 5–12 years.⁷³ Additionally, if one possesses one gram or more of an illegal drug, it will be considered possession with the intention to sell.⁷⁴ This crime is punishable by life imprisonment.⁷⁵ Furthermore, persons may be punished for use or possession occurring abroad.⁷⁶

It also criminalizes the use of a medical drug without the proper prescription from a certified doctor.⁷⁷ Additionally, even if a person is authorized to use a drug for a medical purpose, possession of more than the permitted amount can result in imprisonment or banishment for ten to fifteen years.⁷⁸

The law does not only focus on the substances and modes of intoxication, but cracks down stringently on all avenues that lead to the very state of intoxication: section 4(iii) disallows "the use of anything even if it isn't an illegal drug or a medical drug for the purpose of getting intoxicated."⁷⁹

If a person changes a doctor's prescription in order to obtain a medical drug, or otherwise misuses a prescription, s/he is punishable with imprisonment or banishment for a period of 2–5 years.⁸⁰

The "acceptance, possession or the use of any money or property acquired through illicit activity under the law or which is suspected to have been achieved through the same"⁸¹ is proscribed.

71 Section 4(a)(i).

72 Section 4(b).

73 Section 4(c).

74 Section 2(b).

75 Section 2(c).

76 Section 17.

77 Section 4(a)(ii).

78 Section 3(d).

79 Section 4(iii).

80 Section 5.

81 Section 6.

Writing, publishing an article, drawing an advertisement or poster, or giving a talk or any other activity which creates an interest in others to do drugs is disallowed.⁸² Many Maldivian government officials and other stakeholders believe education or information pertaining to injecting drug use will "encourage" such drug use.⁸³ Consequently, programs ranging from education on needle exchange to less controversial HIV education workshops could be prohibited under this provision.

Persons facilitating the use of drugs in the public are punishable with imprisonment or banishment for 7–15 years.⁸⁴ Such a section can be interpreted to outlaw drug substitution programs entirely.

Certain categories of persons are given the maximum penalty if found guilty of such drug related offences. These persons include: those who do something illegal after committing a crime specified in the law, repeat offenders, persons who help give drugs or administer drugs into the body of a minor less than 18 years, patient under parts 11 and 12 of Act, mentally ill persons, persons who help send drugs into body of person in the event that this person dies or the person's life is endangered, and a person who works in the health field or pharmacist who used his job or his influence to commit a crime. The implication of this section on harm reduction programming is that pharmacists or other health professionals involved in drug substitution could be sentenced with stringent penalties.

Money, tools and instruments, and drugs used to commit a crime mentioned in this law can be confiscated.⁸⁵ Thus drug paraphernalia even when used as part of harm reduction may be seized by services enforcement officials.

82 Section 7(a)(i).

83 See interviews cited above, n14, n20, n25, n49 above.

84 Section 7(b).

85 Section 10.

(d) Treatment and rehabilitation

Drug addicts may be incarcerated or sent for treatment.⁸⁶ However, "drug addict" is not defined. Judges are mandated to consult a statutorily-created committee before sentencing a person for drug use or possession for purposes of use. The law designates such a committee, known as the Drug Rehabilitation Committee (DRC), to decide which drug addicts should be given treatment and to monitor the methods used for treatment.⁸⁷

This committee works under the orders of, and its composition is determined by, the Ministry of Health and Welfare.⁸⁸ The committee consists of five members: a certified lawyer, a medical doctor, a psychiatrist or psychologist or one with social knowledge.⁸⁹ Drug offenders can be referred to the DRC by the Courts, or they can voluntarily request rehabilitation through the assessment committee of the National Narcotics Control Bureau (NNCB). It should be noted that a person cannot voluntarily request rehabilitation after they are arrested. According to Maldivian officials, a Presidential decree issued recently allows addicts to be compulsorily taken in for drug treatment.⁹⁰ Furthermore, if the committee approves, the judge must then suspend the sentence for not more than three years, and the user must undergo treatment at the DRC.

If a person undergoing treatment completes treatment successfully, the remainder of their suspended sentence need not be carried out.⁹¹ If there is a relapse, the full sentence is required to be carried out.⁹² According to officials, treatment is offered after completion of the sentence as well.⁹³

One of the concerns regarding this process arises in the event of relapse: if a drug offender relapses, or fails to complete treatment, the suspension of the sentence is cancelled and they are "re-sentenced". Such sentencing occurs even if they voluntarily entered the DRC program.⁹⁴ The unfortunate consequence of such a provision is that many drug users are reluctant to enter the rehabilitation program⁹⁵ for fear of re-sentencing.

If the sentence pertains to a first-time offender under the age of 16, the judge is obliged to suspend the sentence for three years.⁹⁶ If there is a second offence during suspension, the suspension is revoked, and the first sentence must be carried out, possibly with the second sentence.⁹⁷

(e) Statutory structure for implementation

The primary government body focused on intensifying efforts to effect demand reduction is the National Narcotics Control Bureau (NNCB). The NNCB was established on 16 November 1997, under the Office of the President. The NNCB is responsible for coordinating demand reduction efforts, managing rehabilitation programs and liaising with national and international drug control and law enforcement agencies. The government, through the NNCB, has also undertaken a massive drug awareness campaign.⁹⁸

The Ministry of Defence and National Security conducts arrests and seizures related to illicit drugs in the country. This entity includes a Drug Control Bureau (DCB) that undertakes drug intelligence and investigation, narcotics identification, surveillance, seizures and arrests. Police headquarters, an entity partnering in demand reduction programs

86 Section 11,

87 Section 11(a).

88 Section 11(a).

89 Section 11(a).

90 Feedback on the overview and findings of the report from Razeena Tutu Didi, Asst Director General, NNCB and National Focal Point for Project H13 at the Regional Tripartite Review Meeting, Colombo, Sri Lanka, 30-31 March 2006

91 Section 13(a), Narcotics Law.

92 Section 13(b).

93 Feedback on the overview and findings of the report from Razeena Tutu' Didi, Asst Director General, NNCB and National Focal Point for Project H13 at the Regional Tripartite Review Meeting, Colombo, Sri Lanka, 30-31 March 2006

94 Section 12. See also interview with NNCB counsellors.

95 Ibid.

96 Section 14.

97 Section 15(b).

98 DRRR, Interview with Ahmed Mohamed and Razeena Tutu Didi above n75.

conducted by NNCB, also works on prevention and awareness programs. Seizures are also carried out by the Maldives Customs Service. The Customs Service works with the NNCB in their Advisory Committee on treatment and rehabilitation, and participates in prevention and awareness programs.⁹⁹

(f) Children

The focus of the community and the government's work with children is on drug use.¹⁰⁰ Section 22 of the Law on the Protection of the Rights of Children¹⁰¹ ("Children's Law"), mandates that "parents shall take measures within their power to prevent their children from abusing narcotics drugs."¹⁰² Special attention is to be given under the law to children in the prevention of epidemics. Maldives has recently harmonized its laws with the Convention on the Rights of the Child, so the definition of "minor" extends till age 18.¹⁰³

(g) Law reform

The Law on Narcotics is currently under review. The NNCB feels that the sentences for users are too harsh, particularly since most offenders are young.¹⁰⁴ Representatives of the NNCB stated that young offenders are getting locked up for too long and are ultimately coming out as "hardened" criminals.¹⁰⁵ It acknowledges that the sentence for users should be modified to one year.¹⁰⁶ A consultative process of redrafting has been initiated, inviting comments from a range of stakeholders including law enforcement agencies, the Attorney General's office, NNCB counselors, NGOs and ex-addicts.¹⁰⁷ This move towards decriminalization marks a

shift in understanding the societal impact of criminalizing drug use.

Even if there is a shift in the government towards accepting harm reduction as legitimate, the Law on Narcotics grants authority to the President's appointees to make rules to enforce the law. Based on anecdotal evidence, it is evident that a shift in policy or programmatic support must come "from the top" for harm reduction to be legally and socially accepted.¹⁰⁸

2.3 Policy Framework for Drug Use and HIV/AIDS

2.3.1 Drug demand reduction

The law enforcement agencies working on drug demand reduction include the NNCB, the Maldives Customs Service and the Ministry of Defence and National Security. See Section on "Statutory Structure for Implementation", above.

2.3.2 HIV/AIDS

In Maldives, there is no statute pertaining to HIV/AIDS.

The Ministry of Health formulated a National Policy on HIV/AIDS (Policy), which espouses the principles of confidentiality, non-discrimination and informed consent. It mandates the raising of awareness about HIV transmission through the various modes. It calls for care and treatment of positive persons, and for a thorough information, education and communication program.

It states that HIV testing should be voluntary and that informed consent should be taken, "except when there is sufficient grounds to believe that such testing is essential to protect the health of others." This provision is used to justify widespread mandatory testing of incoming persons and "high-

99 Ibid.

100 Interview with Aishath Shiham above n25, Ahmed Mohamed, Director General, Narcotics Control Board and Razeena Tutu Didi, Assistant Director General of the Narcotics Control Board

101 No. 9/91.

102 Section 22 of Children's Law.

103 See interview with Aishath Shiham above n25.

104 Ibid.

105 Ibid.

106 Ibid.

107 Ibid.

108 See all interviews from country visit: n14, n20, n25, n49, n75, n111 above.

risk" groups. It is argued that such mandatory testing is appropriate for the Maldivian context because of its small population.

The HIV Testing Policies, Protocol and Guidelines discuss counselling and testing. There are explicit guidelines for harm reduction, especially for drug users. There is a mention of transmission via "blood products".

Surveillance and prevention is conducted by the National AIDS Control Programme, a part of the Department of Public Health.

3. DRUG USE AND HIV/AIDS HARM REDUCTION PRACTICES

3.1 Prevention

3.1.1 Drug use

The Youth Ministry and Children's Bureau work closely to prevent drug use among youth.

3.1.2 HIV/AIDS

(a) *Information education communication/ behavior change communication*

The Department of Public Health (DPH) conducts targeted interventions with seamen and tourists. Various NGOs, including SHE, FASHAN, and KIDS are working to raise awareness about HIV/AIDS.¹⁰⁹

(b) *Condom promotion, Needle Syringe Exchange Programme (NSEP) and oral drug substitution*

Currently, no needle exchange, drug substitution or condom distribution programs exist in Maldives.¹¹⁰ The NNCB and public health community are not supportive of harm reduction programs, since both HIV and IDU rates are very

low.¹¹¹ The NNCB indicated that this stance on harm reduction programs could change if HIV or IDU rates increase.¹¹² At the present time, the NNCB is the only body legally permitted to provide treatment to drug users.¹¹³

A practical understanding of the Maldives is necessary to understand why many Maldivians deem harm reduction contextually inappropriate. Accessibility of condom programming reaches married as well as unmarried persons.¹¹⁴ Furthermore, as a Muslim country, targeted intervention condom distribution is considered to be inappropriate as it could be construed to "encourage" sexual activity outside of marriage.¹¹⁵ No condom distribution occurs in prisons. Such targeted interventions are impermissible since sodomy itself is illegal.¹¹⁶

Similarly, needle exchange programs are not necessary because needles are also widely available.¹¹⁷ The Maldivian response towards condom distribution is equally applicable to needle exchange: it is suggested that such a program could "encourage" injecting drug use and is therefore unwise to implement.

There are no drug substitution programs currently in existence in Maldives.¹¹⁸ Maldivian observers think that they are unnecessary due to low HIV and IDU rates, and will reconsider their views if HIV and IDU rates increase, and if more research demonstrates that harm reduction can work in the SAARC context.¹¹⁹ Interestingly, certain groups are accorded special status, and are licensed by the Ministry of Health to prescribe opium, or afihun. These groups are known

111 Ibid.

112 Ibid.

113 Ibid.

114 Ibid.

115 Interview with NNCB Counsellors above n111, interview with DDG and Program Manager above n20, interview with Mohamed Zuhair above n49.

116 Interviews with DR Police

117 Interview with Ahmed Mohamed and Razeena Tutu Didi above n75.

118 Id. See also interview with NNCB Counsellors above n111.

119 Interview with Ahmed Mohamed and Razeena Tutu Didi above n75, DR Police above n134, interview with Mr. Hussain Zamir above n14.

109 RSA above n7.

110 Interview with Ahmed Mohamed above n75.

as divehi base verin, or local medical practitioners that engage in traditional healing.¹²⁰

(c) *Voluntary Counselling and Testing (VCT)*

There are three VCT sites in Maldives, including the Indira Gandhi Memorial Hospital in Male and the Health Centre in Villingili Island.¹²¹ Furthermore, NGOs such as SHE and FASHAN also conduct counselling.¹²²

There is also mandatory testing for certain groups. Tourists, perceived to be a "high risk" group, and Maldivians returning after spending more than a year abroad, are screened for HIV. Furthermore, these persons are screened again after the "window period", six months after the person's return. All foreigners seeking employment are required to undergo HIV testing.

The DPH provides counselling to persons, mostly foreigners and expatriates, who have tested positive. Most foreigners who come to Maldives are of Indian origin. Many of them are not aware of HIV/AIDS. Ultimately, these persons are sent back to India or elsewhere. According to the DPH, they are sent back, not because of the HIV status but because of the requirement of the work permit.

After a person tests positive, a public announcement is released. According to the DPH, the announcement does not include any details that could identify the individual.

3.2 Treatment

3.2.1 Drug use

The NNCB also runs the first and only Drug Rehabilitation Centre (DRC) on a separate island,

which is a detoxification centre believed to house more than 300 clients at any point of time.¹²³ Drug offenders arrested under the Narcotics Law are sent to the DRC, which is located in Himmafushi. The drug offender spends approximately 6 to 9 months at the DRC undergoing rehabilitation.¹²⁴ After this time is completed, the drug offender is released back to the community but drops into NCB centres for counselling.¹²⁵ During this phase, periodic testing is conducted to determine if they are using drugs. There is reluctance and hesitation among drug users to seek services due to the severely punitive legal framework. As discussed above, the law is being redrafted to introduce benign provisions for drug users. It is hoped that it will increase access to drug treatment.

3.2.2 Treatment for children

If evidence of drug use exists, drug counselling is offered to the child, which includes planning alternative steps and possibly a referral to a detoxification and rehabilitation center.¹²⁶ It is interesting to note that children are placed in a detention system, not in prison, where there is no access to drugs.¹²⁷ The detention centres usually hold ten children at any given time, and there is no drug rehabilitation, counselling or treatment.¹²⁸

3.2.3 HIV/AIDS

No information available on HIV/AIDS treatment in Maldives

120 Interview with Mr. Hussain Zamir *ibid*.

121 WHO/UNAIDS "Coverage of selected services for HIV/AIDS Prevention, Care and Support in low and middle income countries" (2004), available at hivinsite.ucsf.edu/global?page=cr08-mv-00 and post=19 and cid=MV.

122 RSA above n7.

123 US Department of State "Country Profiles: Maldives", available at www.state.gov/g/inl/rls/nrcrpt/2002/html/17947.htm.

124 Interview with NCB above n111 and DRC *ibid*.

125 *Ibid*.

126 Interview with Aishath Shiham above n25.

127 *Ibid*.

128 *Ibid*.

III. COUNTRY ANALYSIS – (E) NEPAL

Nepal is a landlocked country that shares its borders on three sides with India and on the north with China. The economy largely depends on agriculture which accounts for almost 40 per cent of the gross domestic product.¹ Tourism is another sector that supports the economy and earns foreign exchange.²

Almost 50 per cent (12.4 million) of the total estimated population (25.7 million) falls in the age group of 15–49 years.³ A large number of Nepalese population – 40% – live below poverty line and about 54 per cent of the adults are illiterate.⁴ Nepal ranks 143rd on the Human Development Index. Unemployment and migration for livelihood are common.

1. DRUG USE AND HIV/AIDS: RISKS AND VULNERABILITIES

1.1 Drug Use

Cannabis (ganja/dry marijuana) has been traditionally used in Nepal. While hermits and monks smoked ganja to suppress sexual urges and hunger, the general population consumed the same during festive or religious occasions. The government itself reportedly distributed ganja among monks and saadhus during the religious festival of Shivratri. This practice continued until 1995 when it was stopped on the direction of the Ministry of Home

Affairs (MOHA).⁵ This tolerant attitude towards drugs is believed to have drawn foreign tourists popularly called "hippies" in the 1960s to Nepal.⁶ Heroin is believed to have been introduced around the same time and was mostly smoked or chased.⁷

The use of alcohol is widespread in Nepal across all the age groups and the average first exposure to alcohol is at the age of 11.⁸ There has been an increase in incidences of abuse of pharmaceutical drugs in recent times.⁹

There are estimated to be about 70,000 drug users in Nepal.¹⁰ Although drug consumption is more visible among males, there are also female dependent users.¹¹ No data is available on the nature and modes of drug consumption. However, people working in the area note that drug use has been increasing and injecting use is very common among drug users.¹² The most commonly abused drugs in Nepal are cannabis, heroin, cough syrups, nitrazepam tablets, phensedyl, tidigesic etc.¹³

1.2 Injecting Drug Use

Injecting is reported to have emerged in early 1990s with the widespread use and availability

1 Nepal: Economy, see reference.allrefer.com/world/countries/nepal/economy.html.
2 Ibid.
3 UNAIDS, UNICEF, WHO "Epidemiological Fact Sheet: Nepal" (2004).
4 Nepal Economy above n1.

5 Interview with Hemant Malla, Act. Senior Superintendent of Police, Narcotic Drug Control Law Enforcement Unit (NDCLEU)
6 "Revisiting 'The Hidden epidemic' – a situation assessment of drug use in Asia in the context of HIV/AIDS", available at <http://www.chr.asn.au/freestyler/gui/files/pakistan>.
7 Ibid.
8 CWIN Research "Alcohol and Drug Use Among Street Children" (Nepal, 2002).
9 Interview with Padma Sreeshreshtha, LALS, Nepal
10 National HIV/AIDS Strategy 2002-06.
11 Interview with Padma Sreeshreshtha above n9.
12 Ibid.
13 NCDLEU report of confiscated drugs and NGO functionaries

of buprenorphine in injectable form.¹⁴ Of the total estimated drug users, 35,000 are injecting drug users (IDUs) and approximately 40 per cent of these 35,000 are HIV positive.¹⁵

The number of women IDUs appeared to be low.¹⁶ A situational assessment of IDUs in Kathmandu valley found nine female injectors in a sample of 204 IDUs. All were reportedly involved in sex work.¹⁷

Sharing of injection equipment was prevalent and the commonly cited reasons included ignorance, non-availability of clean needles, lack of money to buy disposable injections and fear of disapproval from family and community if seen with injection.¹⁸

Approximately 37 % of IDUs were reported to have sexual intercourse with more than one partner in the previous one year.¹⁹ Use of condoms was found to be very low.²⁰ Sexual risk factors among IDUs, though not very significant, cannot be ignored.

1.3 HIV/AIDS

The first AIDS case in Nepal was reported in July 1988. Since then, the number of people infected by HIV has steadily escalated. As of October 2004²¹, the Ministry of Health (MoH) reported 4,354 HIV cases, 835 AIDS cases and 226 deaths due to HIV-related complications. 97 new HIV cases and 26 AIDS cases were reported in the month that ended in October 2004. Among reported HIV cases, there are 100 males against 28 females²². However, the

number of HIV infections is estimated to be close to 62,000 as of end-2003²³. Though HIV transmission is more prominent through the heterosexual route, HIV prevalence in IDUs has been found to be rising at an alarming rate.

Nepal has witnessed a sharp escalation in HIV prevalence among vulnerable populations, particularly IDUs and sex workers. Prevalence of 0.7% in the mid 90s shot upto 50% among IDUs and 1% among sex workers in 2002.

In 2002, prevalence among the general population was reported at 0.5%, which was up from 0.2% in the year 2000.

2. DRUG USE AND HIV: LAW AND POLICY FRAMEWORK

2.1 Overview of the Legal System

Nepal was unified as a country in 1768. Presently, there are 75 administrative districts that have been divided into five development regions – Far-Western, Mid-Western, Western, Central and Eastern.

Nepal is a constitutional monarchy with a parliamentary form of government. The head of the State is the King while the head of the government is the Prime Minister. The King appoints the leader of the majority party as the Prime Minister and the cabinet is appointed on the recommendation of the Prime Minister.²⁴

The political situation in Nepal has been unstable for the last few years. Following the increase in violence by Maoist insurgents, who have been fighting for a communist republic since 1996, the King imposed a 6-months emergency rule on 26

14 Nepal HIV Drug Assessment Report (June 1999).

15 The Rising Nepal (17 April 2004).

16 Burrows, Panda and Crofts "HIV/AIDS Prevention Among Injecting Drug Users in Kathmandu Valley" (January 2001) available at www.chr.asn.au/freestyler/gui/files/NepIDUKathValley.pdf.

17 Ibid.

18 Ibid.

19 Ibid.

20 Ibid.

21 Interview with Ram Prasad Shrestha, Director, National Centre for AIDS and STD Control (NCASC).

22 World Bank report on Nepal, available at <http://web.worldbank.org/WBSITE/EXTERNAL/COUNTRIES/SOUTHASIAEXT/NEPALEXTN/0,,menuPK:148707pagePK:141159piPK:141110theSitePK:223555,00.html>.

23 Epidemiological Fact Sheets above n3.

24 US Department of State "Country Profile: Nepal", available at www.state.gov/r/pa/ei/bgn/5283.ht

* Nepali calendar (Vikram samvat) is 57 years ahead of Gregorian calendar.

November 2001. There have been no elections since 1999 and a caretaker government is currently in charge. Pending elections the House remains dissolved. This political instability impacts the law-making process, as law has to be made via Ordinances, without any political or public debate.

2.1.1 Constitution

The first effort to have a written Constitution was made in 1948 when a Constitutional Reform Committee was set up. The Constitution containing some democratic principles was drafted but was never enforced due to fear of dilution of control. Following the return of the monarch to power in 1951, the King proclaimed an Interim Constitution. This Interim Constitution was replaced in 1959 with the Constitution that introduced the system of democratically elected parliament, though the ultimate powers remained with the King. The 1959 Constitution lost its force, following the adoption of the Panchayat Constitution in 1962. The Panchayat Constitution abolished all political parties and ultimate powers remained with the King. The Panchayat Constitution remained in force till 1990 when the democratic movement became so strong that the King was forced to adopt a multi-party system through a new Constitution.²⁵ The King accepted the present Constitution on 9 November 1990.

Part 3 of the Constitution confers fundamental rights. The Constitution stipulates that all citizens of Nepal are equal before the law and no person shall be denied equal protection of the law.²⁶ No citizen shall be discriminated in the application of general laws on grounds of religion, race, sex, caste, tribe or ideological conviction.²⁷ Further, the State cannot discriminate against citizens

on the aforementioned grounds; however, it can make laws for protection and advancement of the interests of women, children, the aged, or those who are mentally or physically challenged or for a class which is economically, socially or educationally backward.²⁸

Citizens have the right to freedom of (a) opinion and expression, (b) assembly, (c) forming unions and associations, (d) movement and residence throughout Nepal and (e) practice any profession or occupation. These freedoms are however subject to reasonable restrictions by laws made in this behalf. Freedom of opinion and expression can be curtailed if contrary to decent public behaviour or morality. Similarly, freedom to practice any profession can be restricted if it is contrary to public health or morality. The State also has powers to impose conditions by law on carrying of any trade, profession or occupation.²⁹ No detained person can be subjected to mental or physical torture or meted out cruel, inhuman or degrading treatment. Every detained person has a right to know the grounds of detention and s/he should be produced before the appropriate Court of law within a period of 24 hours of such an arrest.³⁰

The Constitution also recognizes the right to privacy of a person and information relating to her/him.³¹

2.1.2 Courts

The Muluki Ain (Country Code of Nepal) was introduced in 1854 combining Hindu religious scriptures and customary laws and is the main legal code for administration of justice. Prior to its adoption, magistrates and justices had extensive powers to decide cases on their own interpretations of the law. Though amended several times, the Muluki Ain was completely revised in 1963 to include criminal and civil law.

25 * Nepali calendar (Vikram samvat) is 57 years ahead of Gregorian calendar.

Country Guide: Nepal, available at <http://reference.allrefer.com/country-guide-study/nepal/nepal100.html>

26 Article 11(1), Constitution of Kingdom of Nepal.

27 Article 11(2).

28 Article 11.

29 Article 12.

30 Article 14.

31 Article 22.

In 1951, reforms were undertaken to change the judicial system. In 1952, the Supreme Court Act established the Supreme Court as the highest judicial authority.

The Constitution provides a three-tier structure of judicial hierarchy. The District Court is the Court of first instance and the principal Court in each district and tries all the civil and criminal cases falling under its jurisdiction.³² There is no distinction between Criminal and Civil Court except some basic procedures.³³ A Tahasildar (Execution Official) is responsible for execution of the judgments – imprisonment or fines. Appellate Courts, which form the second tier in judicial administration, hear appeals against judgments delivered by District Courts and quasi-judicial bodies,³⁴ issue writs in matters of violation of civil rights,³⁵ and hear certain cases specified under the law or transferred by the Supreme Court.³⁶ The Appellate Courts have been established in different geographical locations with distinct jurisdiction. In addition to district and appellate Courts, Courts or tribunals may be set up for hearing special types of cases.³⁷ The Supreme Court is the highest Court in the judicial hierarchy and except for the Military Court, all the judicial institutions are subordinate to it.³⁸ Though the Supreme Court is the Court of last resort, the King has powers to grant pardons and to suspend, commute or remit any sentence passed by any Court or other judicial or quasi-judicial authority.³⁹

2.2 HIV/AIDS Harm Reduction Law

2.2.1 Mandatory testing

The Infectious Disease Control Act, 2020 (1963) confers powers on the government to issue an

order to test people or a group of people and also to segregate them and keep them separately and restrict their movement to control the spread of the disease.⁴⁰ Reports suggest that an executive order was issued in 1989 that allows the government to compulsorily test any person suspected of having HIV.⁴¹

2.2.2 Drug use

The Narcotic Drugs (Control) Act, 2033 (1976) (hereinafter NDCA) and the Drug Act, 2035 (1978) deal with narcotic drugs and pharmaceutical drugs respectively. The NDCA was passed in 1976 and was amended in 1981 and 1987. Pharmaceutical drugs are regulated by the Drug Act 2035.⁴²

(a) Nature and classification of drugs

Cannabis⁴³ and narcotic drugs⁴⁴ have been defined under the NDCA. The Department of Drug Administration (DDA) has also classified drugs⁴⁵ in Schedules A, B and C. Schedule A contains

40 Section 2(1) and 2(3), Infectious Disease Control Act, 2020

41 Forum for Women Law and Development HIV/AIDS and Human Rights: A Legislative Audit 2ed (Kathmandu, June 2004) at 13.

42 Section 23A, Narcotic Drugs (Control) Act 2033 provides that the production, sale and distribution, export-import, store and consumption of shall be regulated through the Drug Act 2035.

43 Section 3 (b), Narcotic Drugs (Control) Act 2033 defines cannabis to mean –

"1. Any plant or genus cannabis including hemp and siddha and also includes the leaves and flowers thereof.

2. Natural resin, gum, and sap obtained from Charas (hashish) and cannabis plants, and

3. Any substance containing any of the extract, substance, essence, mixture and beverage containing any of the substances mentioned above."

44 Section 3 (a), Narcotic Drugs (Control) Act 2033 defines 'Narcotics' as:

1. Cannabis
2. Medicinal cannabis
3. Opium
4. Processed opium
5. Medicinal opium
6. Plants and leaves of coca and 6A. Any substances to be prepared by mixing opium and extract of coca, including mixture or salt
7. Any natural or synthetic narcotic drug or psychotropic substances and their salts and other substances as may be specified by the government by a notification published in the Nepal gazette, from time to time.

45 Section 17, Drug Act 2035.

32 Section 7, Administration of Justice Act 1991.

33 Supreme Court of Nepal, www.supremeCourt.gov.np/general_info_files/body.htm

34 Section 8(1), Administration of Justice Act.

35 Section 8(2).

36 Section 8(3).

37 Article 85, the Constitution of Kingdom of Nepal

38 Article 86.

39 Article 122.

narcotics, psychotropic and poisonous drugs. Schedule B contains antibiotics, hormones and general therapeutic agents i.e. prescription drugs. Schedule C lists common drugs that are available over-the-counter.

(b) Offences and penalties

The NDCA prohibits cultivation, production, preparation, purchase, sale, distribution, export or import, trafficking, storing or consumption of cannabis and other narcotic drugs.⁴⁶

Preparation means the solid or liquefied mixture of one or more narcotic drugs to be prepared in the form of dosage.⁴⁷

Addiction has been defined as an act of consumption of narcotic drugs in more than the dosage and quantity under the prescription of recognised medical practitioner or without the prescription of such medical practitioner.⁴⁸

Consumption of cannabis is punishable with 1 month imprisonment or fine up to Rs. 2,000.⁴⁹ Consumption of opium, coca or any other narcotic drugs made therefrom is punishable with one year imprisonment or fine up to Rs. 10,000.⁵⁰ If a person becomes addicted to any natural or synthetic narcotic drugs and psychotropic substances, as notified by the government, s/he will be liable for punishment up to 2 months and up to a fine of Rs. 2,000 or both.⁵¹ However, all these provisions vest discretion in the judiciary to allow an addict to undergo treatment on certain conditions.⁵²

Consumption of narcotic drugs in the recommended dosage on a prescription by the recognised medical practitioner for medical

treatment is not an offence.⁵³ Section 6 provides that nothing in the Act prohibits/prevents the government or any institution working under its supervision and control after obtaining a special license for selling narcotic drugs to any person on the recommendation of a recognised medical practitioner.

The Act authorizes the government to frame rules and issue guidelines for the production of hashish from wild cannabis plants and acts done in accordance with the license issued for it cannot be deemed to constitute an offence.⁵⁴

If the owner or the person in possession of any building, land or vehicle permits any prohibited act to be committed on his premises, s/he is punishable with an imprisonment from 6 months to five years or with a fine upto Rs.10,000.⁵⁵

A repeat offender under the NDCA is punishable for each subsequent offence in addition to the prescribed punishment with an imprisonment for a term which may extend to five years and with a fine up to Rs.1,00,000.⁵⁶

A person who conspires, attempts, abets or is an accomplice in an offence, which is punishable under the NDCA, is punishable with half the punishment that is due to the actual offender.⁵⁷ These provisions can be used against service providers/private NGOs that run NSEP or provide Oral Substitution treatment without a permit.

None of the provisions of the NDCA explicitly state that distribution of needles/syringes to drug users is a crime. However since drug consumption is a crime, a person or organisation "facilitating" the consumption of illegal drugs through means of distribution of needles and syringes could be considered as an abettor, conspirator, accomplice.

46 Section 4, Narcotic Drugs (Control) Act 2033.

47 Section 3 (h).

48 Section 3 (j4).

49 Section 14(1)(a).

50 Section 14(1)(e).

51 Section 14(1)(h).

52 Discussed in detail under 'Treatment and Rehabilitation of Drug Users' section.

53 Section 5, Narcotic Drugs (Control) Act 2033.

54 Section 4(1).

55 Section 15.

56 Section 16.

57 Section 17.

In 2002, the Department of Drugs and Natural Calamities Management under the MOHA and NCASC issued two separate letters that stopped free distribution of sterilised syringes. The letter issued by the MOHA stated that drug consumption was a criminal offence under the law and the programme of syringe exchange and injection was also considered a crime under the law.⁵⁸ Further, an NGO expressed that the general community too does not understand the public health rationale of IDU interventions and perceives needle-syringe exchange programs as encouraging illicit drug consumption.⁵⁹

(c) Powers and procedures

The NDCA empowers the Narcotic Drugs Control (NDC) Officer to issue warrants and search any person if he has reason to believe that such a person has committed or is about to commit an offence that is punishable.⁶⁰ The NDC Officer or a police officer of the rank of Assistant Sub-Inspector is empowered to enter, search, seize and arrest without a warrant if he believes that the offence is being committed in a building, land, vehicle or other place and the offender may escape or the evidence would be erased. However, such an entry, search, seizure shall be made in the presence of a public witness.

The NDC Officer is required to produce the person arrested or the goods seized before the Court within 24 hours of such an arrest or a seizure.⁶¹

Information about transaction in narcotic drugs or the use of narcotic drugs which leads to proving an offence and fining of the offender, entitles the informer to receive 20 % of the amount of the fine as reward.⁶²

Secrecy can be maintained in respect of the name of the person or the documents involved on request of the party filing the case.⁶³ However, the government is always the plaintiff under the NDCA.⁶⁴

The NDC Officer has the discretion to release a person who is found in possession of cannabis, medicinal opium in small quantity without commercial motive on making her/him sign an undertaking not to repeat such an offence and on recording reasons for such release. Courts can exercise similar powers on the initiation of prosecution.⁶⁵

The person who was found to be in possession of narcotic drugs has to prove that narcotic drugs possessed by him are in accordance with the provisions of the NDCA. If he fails to do so, he will be deemed to have committed an offence and will be punishable under the NDCA.⁶⁶

(d) Treatment and rehabilitation of drug users

Treatment Centre has been defined in the NDCA to mean a treatment centre approved by the government for the treatment and rehabilitation of narcotic drug addicts.⁶⁷

Courts are empowered to divert drug addicts to treatment programs. Also, any person or institution can enter into a bond on behalf of a cannabis addict to undergo treatment for a month. In such cases, the judicial authority may not punish the cannabis addict on submission of fortnightly reports of treatment.⁶⁸ Similar provisions exist for persons addicted to opium or any natural or synthetic narcotic drug and psychotropic substance, where treatment is carried on for three months.

58 HIV/AIDS and Human Rights: A Legislative Audit above n45 at 16.

59 Interview with Padma Sreeshreshtha above n9.

60 Section 7, Narcotic Drugs (Control) Act 2033.

61 Section 10.

62 Section 18B.

63 Section 9A.

64 Section 22.

65 Section 19.

66 Section 12.

67 Section 3 (j3).

68 Section 14 (1)(a).

The Chief Narcotic Control Officer has the authority to distribute 20 per cent of the fine levied in respect of an offence under the NDCA to the treatment centre.⁶⁹ However, the actual practice in this behalf could not be ascertained.

Another benign provision is to offer immunity from proceedings to a narcotic drug addict/consumer who is undergoing treatment in a treatment/rehabilitation centre established or recognised by the government for offences committed under section 14(a) and (e) i.e. consumption of cannabis and opium.⁷⁰ Except for a very few government established detoxification centres in Nepal, these services are largely provided by the NGOs. These NGOs have to register themselves with the MOHA and the Ministry of Social Justice, who confer recognition required under law.

The Social Welfare Act 2049 (1992) is another legislation that provides the government with a mandate to carry out special programs that enable drug dependent persons to live a dignified life.⁷¹

(e) Law reform

An attempt to bring about amendment in the NDCA was made in 2002 when an "NGO Bill" was introduced in the Parliament. Reportedly, it had the active support of Nepal Bar Association and NGOs working in the field. That effort to amend the law, however, was unsuccessful as Parliament was dissolved immediately after introduction of the Bill.⁷² Reportedly, the main contents of the Bill were recognition to NSEPs and oral substitution, drug users' right to treatment, regulation/licensing of medicine shops to sell drugs and needle and syringes etc.⁷³

Even after the dissolution of Parliament, there has been pressure on the government from certain sections of the society and interest groups to amend the law in such a way so as to legally recognise Needle Syringe Exchange Programs.⁷⁴ However, as Parliament remains dissolved and a caretaker government exists, any amendment to the law is possible only through an ordinance, which has to be re-introduced and passed every six months to be kept in force. It is apprehended that changes would be demanded at each instance of renewal of the Ordinance.⁷⁵ As a result, no legal changes have been introduced.

(f) Structure for implementation

Supply and Demand reduction of illicit drugs is handled by two different units. The implementation of the Narcotic Drugs (Control) Act is the responsibility of the Narcotic Drug Control Law Enforcement Unit (NDCLEU) while demand reduction is entrusted to the Drug Control Programme (DCP), formerly the Drug Abuse Demand Reduction Project (DADRP), that works for the prevention, treatment and rehabilitation of addicts.

The Chief District Officers across 75 districts have been designated as drug control officers. The main focus of the NDCLEU is to book traffickers. The provisions of the Narcotic Drugs Control Act are generally not invoked against users possessing small quantities unless they are suspected to be peddlers.⁷⁶ Another reason why users are not caught is that the local police are unable to handle their withdrawal symptoms. Custody deaths of users in 2000-2001 has made the police wary of arresting addicts. The police has now started taking the arrested addicts to the general hospital for withdrawal management. Under the NDCA, the NDCLEU arrested 564 persons in 2000, 348 in 2001, 316 in 2002, 428 in 2003 and 361

69 Section 18E.

70 Section 19A.

71 Section 4(3), Social Welfare Act 2049

72 Interview with Rishi Raj Ojha of Nepal Harm Reduction Council (November 2004)

73 Ibid.

74 Interview with Kumar Prasad Poudyal, Joint Secretary, Ministry of Home Affairs.(November 2004)

75 Article 72 of the Constitution and interview with NCASC official

76 Interview with Hemant Malla above n5

till October 2004.⁷⁷ Though the break-up of the number of arrested users, peddlers and traffickers is not available, the NCLDEU official reported that the focus has been to apprehend traffickers and not users,⁷⁸ who face arrest only if involved in drug trafficking.⁷⁹

The government has set up the Narcotics Control National Co-ordination Committee (NCNCC) under the chairmanship of the Home Minister. The NCNCC is responsible for taking policy decisions and has members from other ministries such as Health, Finance, Social Welfare and the Chief of Police. The NCNCC has delegated powers to the Executive Committee to take decisions for execution of policy recommendations made by NCNCC.

2.3 Drug Use and HIV/AIDS Harm Reduction Policy

2.3.1 Drug use

In 1992, the Government of Nepal formulated a five year (1992-96) Master Plan for Drug Abuse Control in consultation with the United Nations Drug Control Programme (UNDCP). Some important aspects of drug use identified under the Master Plan were: revision of narcotics legislation, expansion of treatment and rehabilitation services, policy formulation in the field of preventive education and information etc. It also proposed two plans, one for "legislation and law enforcement" and the other for "treatment, rehabilitation and other demand reduction activities".⁸⁰ It observed that "placing the drug addicts in the custody of police or confining them in jails is acceptable as a short-term interim measure but its medium and long-term viability is open to questioning on legal, medical and moral grounds." Further, it identified

the deficiency in availability of detoxification and rehabilitation centres in Nepal. The Plan still looked at drug abuse as an independent problem devoid of any link with HIV.⁸¹

The National Drug Demand Reduction Strategy (1996-99) was drafted under the Drug Abuse Demand Reduction Project (DADRP) in cooperation with UNDCP in February 1996. Its overall objective is elimination of drug use, articulated in its mission, "to create, using socio-culturally acceptable strategies, a national climate in which the non-medical use of drugs is virtually non-existent". The document noted the growing nature of the drug problem in Nepal and sought to create a multi-sectoral response by involving other ministries. Hitherto, drugs were seen as a law and order problem alone to be dealt with by the MOHA and the Police department.

The National Strategy also proposed inclusion of drug education in the school curriculum for grades 6 to 10 in formal as well as non-formal educational institutions by involving the Ministry of Education (MoE). The strategy emphasised the need to integrate the HIV prevention in drug education and information campaigns. Significantly, the national strategy accepted drug maintenance/substitution as a treatment option and proposed to have "50 per cent of hard core and chronic addicts avail of methadone or other drug substitution therapy in the Mental Hospital". While acknowledging NGO efforts towards social rehabilitation of addicts, the Plan committed financial support to organisations providing drug related services and support. Notably, the strategy document recognised the problem of drug dependency in prisons and proposed to provide a range of services including oral substitution. It further expressed the need to provide separate facilities for drug dependent women.⁸²

77 NDCLEU Report of arrests made since 2000 (on file with author).

78 Interview with Hemant Malla above n5..

79 Feedback on overview and findings of the review from country experts at the Regional Tripartite Review Meeting, Colombo, Sri Lanka, 30-31 March 2006

80 Nepal HIV Drug Assessment Report above n14.

81 Ibid.

82 National Drug Demand Reduction Strategy 1996-99 (unofficial translation).

The strategy period expired in 1999. No other drug policy or plan has been framed since.

2.3.2 HIV/AIDS

Following the rise in Sexually Transmitted Diseases (STD), the STD Control Committee was established in 1986 by the government. This Committee was later upgraded to National Centre for AIDS and STD Control (NCASC) as a semi-autonomous organisation.

A short-term AIDS Control Plan was devised in 1988 following the reporting of the first AIDS case in Nepal. This was followed by a medium-term plan for a two-year period (1990-92). Reviewing the HIV/AIDS situation and experiences of government departments and NGOs in controlling STDs and HIV, a long-term plan (1993-97) was formulated. Following this, a Strategic Plan (1997-2001) was launched by NCASC. It was in this Plan that the need to provide sterile needles to IDUs through NGOs was first proposed. It also proposed a review of legal regime around illicit drug use.

National HIV/AIDS Strategy 2002-06

The 20-year long-term National Health Plan (1997-2017) does not focus on the growing problems of HIV/AIDS.

The National Reproductive Health Strategy 1998 deals with STI/HIV/AIDS to a certain extent.

In October 2002, the government formulated a comprehensive five-year HIV/AIDS Strategy (2002-06) that advocates a rights-based strategy to stem the epidemic.

The HIV/AIDS Strategy 2002-06 identifies sex workers and their clients, IDUs, mobile labour population, Men having sex with men (MSM) and prisoners as a 'nucleus' for a generalised epidemic after an NCASC commissioned situational assessment noted that Sex Workers and IDUs

need treatment interventions. The Plan notes with concern the increasing rate of HIV infection among sex workers and IDUs.

The National Strategy acknowledges that "cultural, economic and social constraints limit sex workers' access to legal protection and medical services". It advocates 100% condom use and supports the adoption of a strategy to push the use of condoms by educating pimps and madams about the importance of condom usage and to adopt an informal "no condom, no service, no refund" policy.

The strategic document proposes to "increase awareness among policy makers about the existence of MSM and the risks that they face and to laws and policies that exacerbate vulnerability".

The document admits that there is not enough information available in Nepal about the existence of HIV among prisoners. However, it observes that "the prison situation world over has been characterised by use of drugs and sexual relationships between men and sexual harassment of women", thus suggesting that it exists in Nepal also. It seeks to provide access to quality care and support to prisoners living with HIV/AIDS and to allow the distribution of condoms in prisons.

In order to control the spread of HIV among migrating labour, the strategy document suggests, among other things, to establish pre-departure and post-arrival information and counselling services and bilateral meetings between the officials of India and Nepal as regards HIV/AIDS and mobility.

Strategies for IDUs

Nepal, the strategy document notes, was the first developing country to identify the importance of intervention among IDUs and implement the NGO-run 'Harm Reduction Programme' including needle-exchange for IDUs.

The main thrust of the Strategy is the creation of an environment wherein harm reduction interventions can be scaled up. It proclaims that the harm reduction approach gives drug users options to reduce the risk of HIV infection and hence espouses positive/affirmative rather than punitive strategies. Though elimination of drug use is the ideal and final goal, the Strategy identifies intermediate goals of safer injection techniques and drug substitution therapy as the means to stop HIV transmission in IDUs.

The following strategies are propounded for harm reduction:

- ◆ Building capacity for the establishment and rapid expansion of harm reduction programs including those for "needle and syringe exchange" and "drug substitution therapy".
- ◆ Expanding peer-education training and programming using IDUs as the primary facilitators/peer-educators.
- ◆ Developing and gradually implementing appropriate support services for IDUs (counselling, primary health care, harm reduction based education, legal support).
- ◆ Developing guidelines, policies, and capacity for the rehabilitation of injecting drug users.

The policy recognises the importance of research in identifying the behavioural patterns, practices and networks related to IDUs in order to monitor the effectiveness of existing interventions. It also emphasises awareness programs in schools and development of appropriate Information, Education and Communication (IEC) to inhibit drug demand.

3. DRUG USE AND HIV/AIDS HARM REDUCTION PRACTICES

3.1 Prevention

3.1.1 Drug Use

The DADRP (Drug Abuse Demand Reduction Project) was set up in 1996 to co-ordinate drug

demand reduction between government and NGOs. Though the government does not own any treatment centre as such, it provides training to NGOs that are interested in setting up the treatment centres. It also undertakes training on drug abuse prevention in teachers, health workers, sports persons as well as community leaders. The DADRP has recently started publishing IEC material to create awareness in the community about drug abuse, including quarterly newsletter, posters, pamphlets, leaflets, video film, slides and training manuals.

3.1.2 HIV/AIDS

(a) *Information education communication/behaviour change communication*

The low literacy rate poses problems in creating awareness about HIV/AIDS apart from other factors such as difficult terrain, underdeveloped communication means etc. A government survey conducted in 75 districts revealed that only 71.7 per cent of males and 49.6 per cent of females had ever heard of HIV/AIDS.⁸³

The introduction of HIV/AIDS and drug education in schools is noteworthy. With the approval of the MoE and the Curriculum Development Council, drug education has been incorporated in school education for grades 6 to 10 and has been allotted assessment marks for that too. The MoE has also introduced HIV/AIDS education for grades 9 and 10 under the subject of "health education".⁸⁴ The MoH in collaboration with UNICEF has designed an age-appropriate curriculum on sex education for young persons, which is to be pilot tested. Attempts are underway to develop lessons for students as young as 6 and 7 years on the dangers of drug use and HIV/AIDS.⁸⁵

83 Ministry of Population and Environment, www.mope.gov.np/population/chapter6.php

84 Interview with Ram Prasad Shrestha above n21.

85 Ibid.

Though no formal body is designated to oversee IEC campaigns,⁸⁶ in one instance, the NCASC reportedly intervened to stop distribution of leaflets developed by an NGO that described HIV as a "fatal" disease, as it purported to create fear in the community and increase AIDS-related discrimination.⁸⁷

In response to the problem of human trafficking, IEC material has been developed warning women against the dangers of sex trafficking.⁸⁸ This, however, does not include information about HIV/AIDS risk and prevention.

In the specific context of IDU, an NGO namely, Lifesaving and Lifegiving Society (LALS) has produced several leaflets, one of which describes how to sterilize needle/syringe before injecting drugs while another explains how to inject safely to avoid overdose and other harms. Till date, there has been no impediment from the government and law enforcement agencies in that effort.⁸⁹

(b) STD treatment

The MoH, in co-ordination with NGOs, is providing STD treatment through private and public health institutions.⁹⁰ No other information was available.

(c) Condom promotion

Condoms have been hitherto promoted by the government as a contraceptive for controlling population growth. Additionally, condoms are now being promoted as a means for preventing STDs and HIV/AIDS. Over the years, the number of condoms distributed has shown a consistent rise.

Condoms are available in general shops and stores. A survey conducted by the government in 2001 showed that 70 per cent of women knew where to procure condoms. However, only 34 per cent said that they could obtain condom if they wanted to, indicating the divergence between availability and access. Women carrying condoms are thought to be in sex work and consequently harassed.⁹¹

Some reports suggest that condoms were being distributed in three prisons in Nepal.⁹² This practice was, however, reportedly discontinued by the government. Although no official reasons were cited, it is speculated that the step was seen as encouragement of MSM activity among jail inmates by the government.⁹³

(d) VCT

There are not enough VCT centres, even in the capital city of Kathmandu. Not much could be ascertained of VCTs in other districts of Nepal. The National HIV/AIDS Strategy 2002-06 envisaged setting up of VCTs in 26 districts. The Strategy also aimed at setting up VCT services for priority groups at five sites by 2003. However, the actual achievement in terms of centers could not be ascertained.

On 1 December 2004, Youth Power Nepal, an NGO, started free hotline and counselling on drug addiction and HIV/AIDS.⁹⁴

(e) NSEP

Nepal was one of the first countries in the region to recognize harm reduction interventions including needle-exchange as a strategy to avert HIV transmission among IDUs. The first NSEP was reportedly set up as early as 1991 in the Kathmandu

86 Ibid.

87 Ibid.

88 Hennink and Simkhada "Sex Trafficking in Nepal: Context and Process" Asia Pacific Migration Journal Vol. 13 No. 3 (2004) at 305-338.

89 Interview with Padma Sreeshreshtha above 9.

90 News Report (19 June 2003) www.nepalnews.com.np/contents/englishdaily/ktmpost/2003/jun/jun19/local.htm.

91 News Report (2 August 2003) www.nepalnews.com.np/contents/englishdaily/ktmpost/2003/avg/avg02

92 Nepal HIV Drug Assessment Report above n14.

93 Telephonic conversation with Rishi Raj Ojha, Nepal Harm Reduction Network (3 January 2005).

94 Reported in the Himalayan Times, 6 December 2004.

valley by LALS. Till date, its services are limited to 5,000 IDUs, 6 per cent of which are women. It distributes 20,000–25,000 needles and syringes per month through 82 sites. LALS faced resistance from the local community as the NSEP was seen as encouraging drug consumption. However, this view has substantially changed after concerted efforts were taken by LALS to sensitize the general public, municipal authorities as well as the police.

In 2003, 19 NGOs were reportedly involved in NSEPs in 11 districts of Nepal (18 were actually running NSEPs and 1 was advocating NSEP). This number dropped to 9 in 2004.⁹⁵ No specific reasons were cited for the reduction in service provision by NGO services but lack of financial and technical resources have been considered as limiting factors. Government officials pointed out that NSEPs were not being run in an effective manner as they lacked technical support and the outreach workers were not properly trained. They also claimed that clients at NSEP sites sell the needles and syringes distributed through programs.⁹⁶ This led some NGOs to operate programs strictly on an exchange basis where only 1–2 needles and a syringe are offered to a client at a time against the used needle and syringe.⁹⁷

Outside NSEPs, needles and syringes can be lawfully purchased from pharmacies. Yet access for street users remains difficult. Pharmacists are reluctant to sell the needles and syringes if they think that the buyer is a drug addict.⁹⁸ This reluctance, together with the social stigmatization of IDUs, has inhibited adoption of safer injection practices among the IDU community.

Due to the limited coverage and number of intervention projects, NSEP did not have a significant impact on reducing HIV infections in IDUs. The failure to prevent and control HIV infection rates among IDUs has led some,

including the MOHA which principally does not support NSEPs, to question their efficacy. Some government officials contended that NSEPs are resource intensive and are not showing desired results. Some feel that it would be better to divert finances into treatment and other abstinence oriented programs. On a less critical note, the Ministry has pointed out that IDU harm reduction programs like NSEPs cannot remain stand-alone and must be integrated into larger drug prevention, treatment and rehabilitation schemes.⁹⁹

Health interventions in Nepal are confronted with a daunting challenge; while the burgeoning HIV epidemic among IDUs calls for scaling up of harm reduction responses, support for interventions like NSEPs in crucial quarters appears to be dwindling.

(f) *Oral substitution*

Nepal is the first country in the region that started a government-approved oral substitution programme in the form of Methadone Maintenance Clinic (MMC).

Methadone is a Schedule A drug under the Drug Act 2035 and has to be approved by the MOHA to be imported into the country. Except for one year, Methadone was reportedly procured by the WHO.

MMC began at the Kathmandu Mental Hospital in 1995 as a pilot programme, after approval from the MOHA and MOH. At that time, the clinic did not have facilities for counselling, testing, treatment and rehabilitation.¹⁰⁰ It accommodated only 24 clients in the first year. However, with rising HIV among the IDUs, the number was scaled up to 200 over a period of 5 to 6 years.¹⁰¹

Methadone was administered by specially trained staff, which included a doctor and a nurse. In

95 Interview with Rishi Raj Ojha above n82.

96 Interview with Hemant Malla above n5.

97 Interview with Padma Sreeshreshtha above n9.

98 Interview with Bhupendra Thapa of DDA and Padma Sreeshreshtha.

99 Interview with Kumar Prasad Poudyal above n84.

100 Telephonic interview of Dr. Dhruvman Shreshtha in-charge of MMC (24 November 2004).

101 Ibid.

the initial stage, clients were kept under strict observation to monitor the effect of methadone. Dosages were prescribed individually for clients based on clinical assessment. Clients paid for the drug but no other user fee was charged.

An Impact Evaluation Report was carried out to assess the success of the programme for the period 1995-2000. The criteria to evaluate the success of the programme were: reduction in crime, control of HIV/AIDS, and change in social behaviour of enrolled clients. Though some misuse of methadone was reported, the overall programme implementation was found satisfactory.¹⁰²

The MMC was discontinued in 2002 due to non-availability of funds. Other problems seen in the programme included lack of infrastructure, scarcity of trained staff, and a high dropout rate of clients. Anecdotal reports suggest that the project is being restarted as a comprehensive programme that combines facilities for counselling and HIV testing, needle-syringe exchange programme, treatment and rehabilitation in addition to methadone maintenance.¹⁰³ Concerns have been expressed about the choice of methadone, which tends to foster dependence. In a letter issued to NCASC, the Network Against Drugs and Drug Related HIV has demanded that clear strategies and protocols be adopted and that target/vulnerable groups be involved at the very outset to make the programme successful.¹⁰⁴

Besides the government methadone clinic, another oral drug substitution programme using buprenorphine was being run by an NGO, Naulo Ghumti, with the support of International Nepal Fellowships (INF) in Pokhara. Buprenorphine used to be procured by an arrangement with an international organisation. Unconfirmed reports suggest that the project was stopped after the MOHA withdrew permission.¹⁰⁵

¹⁰² Ibid.

¹⁰³ Ibid.

¹⁰⁴ Reported in Himalayan News Service (1 August 2004).

¹⁰⁵ Interview with Rishi Raj Ojha above n82.

3.2 Treatment

3.2.1 Drug treatment and rehabilitation

There is a huge gap between the requirement and actual availability of drug treatment facilities.

Detoxification is offered at very few government hospitals and for a nominal fee. "One-stop shop" centres offering comprehensive treatment including clinical therapy, client counselling, social rehabilitation and after care are non-existent. As pointed out earlier, the Methadone Maintenance Clinic too was found wanting on provision of comprehensive services.

NGOs have been providing treatment and rehabilitation services since long, but their capacity is far from adequate. Further, funding is available only partially and to cover the costs of the treatment, NGOs charge patients anything between Rs.4,000 and 6,000 per month. This leaves out a large population of drug users, who are willing to get treated but cannot afford these charges from treatment services. Another problem is that of physical access as treatment centers exist only in select locations while drug abuse and addiction is reported from all parts of the country.

3.2.2 HIV/AIDS

The National HIV/AIDS Strategy 2002-06 notes, "Care and support for people living with HIV/AIDS has not been a prioritised part of the national response to the epidemic." It further states, "in a resource poor setting like Nepal, immediate access to anti-retroviral (ARV) therapy and certain other AIDS-related medical interventions is not possible." As of 2003, there were about 4,000 adults who needed ARV therapy.¹⁰⁶ NGOs are providing ARVs to some HIV positive people however their capacity to support ARV treatment is very limited. Information about availability of treatment for opportunistic

¹⁰⁶ Epidemiological Fact Sheet above n3.

infections and management of HIV/AIDS was not available.

The government launched the PMTCT programme on 1 December 2003 in a Kathmandu government hospital. It has plans to further scale up the same involving other government hospitals.¹⁰⁷

Being a low prevalence country, available resources in Nepal are being diverted towards prevention to the exclusion of care and support for those already infected with HIV/AIDS. Additionally, the government health service infrastructure is inadequate to deliver HIV treatment including ARV therapy.

107 Interview with Ram Prasad Shrestha above 21.

The government estimates that it needs US\$ 50 million (approximately NRs. 360 crore) for the implementation of the National HIV/AIDS Strategy 2002-06.¹⁰⁸ It has received US\$ 11 million (approximately NRs. 80 crore) from the Global Fund to prevent HIV/AIDS and malaria¹⁰⁹ and its own budgetary support is only NRs. 4.7 million for the year 2004-05.¹¹⁰ Only NRs.1.4 million was released to the NCASC in the year 2000.¹¹¹ With such small government support, any effort to thwart the growing epidemic through collective implementation of the HIV/AIDS Strategy would be difficult.

108 World Bank information, <http://www.worldbank.org/np>.

109 Ibid,

110 Interview with Ram Prasad Shrestha above n21.

111 Family Planning Association of Nepal.

III. COUNTRY ANALYSIS – (F) PAKISTAN

Pakistan is the second largest country in the region with an estimated population of 149.1 million. Its demographic and health profile is similar to the rest of the South Asian region, characterized by high rates of infant and maternal mortality, low levels of literacy and poor access to health care. Additionally, already crunched health budgets are being stretched to deal with a burgeoning problem of drug dependency and injecting drug use and more recently the HIV/AIDS epidemic.

1. DRUG USE AND HIV/AIDS: RISKS AND VULNERABILITIES

1.1. Drug use

The phenomenon of drug use is not new or unknown to the sub-continent: use of raw opium was an established socio-cultural practice. Till the 1960s, cannabis smoking was confined to the lower economic segments of the population and addiction was not reportedly seen as a social or public health threat.¹ The 1970s saw the introduction of cannabis use among urban youth.² Like the other countries in the region, Pakistan witnessed increased consumption and dependence on heroin in the 1980s, which was inhaled as heated fumes or smoked by mixing with cigarette tobacco.³ By the mid-1990s, over a million heroin dependent users were reported in Pakistan.⁴ The late 1990s saw street-based drug users in the

cosmopolitan cities of Pakistan, especially Karachi and Lahore, inject heroin. Injection of drug cocktails (mixture of pharmaceutical drugs available over the counter) was also reported around the same time⁵. The shift from smoking to injecting heroin and other pharmaceuticals has been attributed to the high cost and difficulty in obtaining heroin (an illicit substance) as compared to the relatively easy availability of legal drugs.⁶

Inhalation of solvents such as adhesive glue, paints, thinner/correction fluid for their psychoactive effects has also been reported as common among street children living in urban poverty.⁷ Although no injecting drug use was reported among those street children dependent on drugs, a research study conducted in the four cities of Lahore, Quetta, Karachi and Peshawar found street children engaging in risky sexual practices under the influence of drugs.⁸ Solvent abuse among young, vulnerable populations is emerging as a serious challenge in the field of drug prevention, education and treatment.

According to the National Drug Abuse Assessment Study conducted by the government in association with UNODC in 2000/01, there are an alarming 500,000 chronic heroin users, including drug injectors (15% or 60,000) in Pakistan.⁹

1 "Revisiting 'The Hidden epidemic' – a situation assessment of drug use in Asia in the context of HIV/AIDS", available at <http://www.chr.asn.au/freestyler/gui/files/pakistan>.

2 Narcotics Control Division, Government of Pakistan "Drug Abuse Control Master Plan for Pakistan" (1998-2003) at 9.

3 Ibid.

4 Ibid.

5 UNDCP and UNAIDS "Baseline study of the Relationship between injecting drug use, HIV and Hepatitis C among male injecting drug users in Lahore" (December 1999) in executive summary.

6 Ibid, Background.

7 UNODC "Solvent Abuse among street children in Pakistan" Publication No. UN-PAK/UNODC/2004/1 (Islamabad, 2004).

8 "Solvent Abuse among street children in Pakistan" above n7.

9 Pakistan Narcotics Division, <http://www.pakistan.gov.pk/narcotics-division/publications/findidngs.jsp>.

1.2 Injecting Drug Use (IDU)

IDU is reported to be an urban phenomenon and on the rise. 60,000 drug users are reported to inject.¹⁰ Of these, an alarming 64% are reported to share injection equipment indicating an imminent threat of exploding HIV/AIDS and Hepatitis C epidemics. While national level statistics are not available, situational assessments from different parts of Pakistan establish the IDU community's susceptibility to HIV/AIDS and the threat of a possible spread of the epidemic in the general population.

One of the earliest disease prevalence assessment studies among street injectors was undertaken in Lahore in 1999 and Karachi in 2002. Out of the total sample, 89% injecting drug users (IDUs) tested positive for Hepatitis C. No respondent tested positive for HIV. The study also found use of contaminated needles and syringe sharing to be widespread. Sexual activity was also reported to be high while condom use was negligible, including with paid partners.¹¹

In 2003, a random screening of heroin dependent users in Larkana, a relatively small city in the Sindh province, found 17 HIV positive cases within a sample of 183 IDUs.¹² Further investigational surveys revealed sharing of needles and syringes, re-use without sterilization of injections, unprotected sex with regular and paid partners – factors contributing to the rapid transmission of HIV/AIDS both among IDUs as well as their sexual partners.¹³

In 2004, a random sampling of IDUs in Karachi found 125 HIV positive cases.

A socio-demographic and behavioural survey of drug users in Quetta, the capital of Balochistan province, also highlights limited knowledge of HIV/AIDS and its prevention, low rates of condom use and widespread re-use of used needles and syringes among injectors.¹⁴

Behavioural assessments have found drug users to be sexually active with both paid and regular partners. This has underscored the need for addressing sexual risks besides preventing risky drug injecting practices among IDUs.

1.3 HIV/AIDS

Though Pakistan lacks a national HIV/AIDS testing, reporting and surveillance system,¹⁵ officially it is estimated that 0.06% of the population is infected with HIV/AIDS.¹⁶ UNAIDS estimates put the figure of Pakistanis living with HIV/AIDS at 78,000 with a prevalence rate of 0.1%.¹⁷

Of the total HIV/AIDS cases officially reported in Pakistan, 55% are reported to be sexually transmitted, which includes 4.16% cases of transmission through homosexual activity.¹⁸ 2.19% cases of HIV/AIDS have been attributed to injecting drug use.¹⁹ The mode of transmission in a significant percent of cases²⁰ remained unknown, once again pointing out to the inadequacies in case monitoring and surveillance.

While officially the country is characterized as a low prevalence setting, behaviors, practices and

10 National AIDS Control Programme, National Institute of Health, Ministry of Health, Government of Pakistan "Programme Implementation Plan" (2003 –2008) at 11. Hereinafter PIP.

11 UNDCP and UNAIDS Baseline study above n5.

12 Nadeem ur Rehman, Kamran Niaz, Faran Emmanuel, Saeed Akhtar, "Factors associated with Transmission of HV among Drug users in Larkana, Pakistan" UNODC, Country Office Pakistan.

13 Ibid.

14 Tariq Zafar, Salman Ul Hassan, Nai Zindagi "A sociodemographic and behavioural profile of heroin users and the risk environment in Quetta, Pakistan" International Journal of Drug Policy 3 (2002) at 121.

15 Nizamuddin Siddiqui, "Karachi: HIV situation is getting alarming says expert" The Dawn (27 September 2004), available at www.dawn.com.

16 UNDP "Reach beyond Borders – HIV and Development Programme" Regional Update, Pakistan, available at <http://www.hivanddevelopment.org/regionalupdate/index.asp>

17 UNAIDS Information (2002), available at http://hivinsite.ucsf.edu/pdf/UNAIDS/barcelona_table.pdf.

18 PIP above n10 at 11.

19 Ibid.

20 Ibid. Data available from March 2002 showed that the route of transmission in 34% of cases of HIV/AIDS could not be assessed.

contexts that predispose people to HIV/AIDS are all reportedly present in Pakistan.²¹ These include poor levels of awareness and knowledge, high prevalence of risky sexual and drug injection practices and minimal negotiation skills especially among marginalized and vulnerable groups. In fact, some point out that prevalence of HIV among "high risk" groups like IDUs has crossed 5% in several places indicating that the epidemic may well be in the concentrated stage.²²

Pakistan is at a crucial juncture vis-à-vis HIV/AIDS prevention and control, especially among groups with risky sexual and injection practices.

2. DRUG USE AND HIV/AIDS: LAW AND POLICY FRAMEWORK

2.1 Overview of the Legal System

Pakistan is a federal republic with four provinces namely – Punjab, Sindh, Balochistan and the North West Frontier Province (NWFP), along with the national capital territory of Islamabad and the territory of Federally Administered Tribal Areas (FATA). The areas under FATA enjoy considerable administrative autonomy; procedural law based on local tribal custom finds its application in the administration of justice in FATA. Some federal and provincial laws have, therefore, not been extended to these areas.

Pakistan is a parliamentary democracy and legislative powers are vested with the Parliament and with the Provincial Assemblies.²³ The bicameral Parliament – Majlis-I- Shoora – consists of the Senate and the National Assembly. The Senate, which is the permanent house, has representatives elected from the provincial assemblies while members of the National Assembly are elected

through parliamentary elections every four years. Parliamentary democracy has, however, on several occasions, given way to other forms of government including military and presidential governments.

The President, who is elected for a five-year term, heads the executive branch of the State.²⁴ The Prime Minister or the Head of the government is appointed by the President from amongst the members of the National Assembly,²⁵ and exercises executive powers for the federal government along with a Cabinet of Ministers. The President enjoys wide ranging powers over the elected government and political and legal developments in the recent past have established the Presidential office as the supreme decision-making/authoritative body in the country.

2.1.1 Constitution

The Constitution of the Islamic Republic of Pakistan has been suspended and restored several times over since its adoption in 1973.

The Preamble to the Constitution proclaims Islamic principles of social justice and declares respect for fundamental rights including equality of status, opportunity and protection of law²⁶ within an egalitarian socio-economic order. The fundamental rights chapter embodied in the Constitution guarantees the preservation of life, liberty, body and property of each person.²⁷ The state cannot prevent or hinder a person from doing something not prohibited under law and cannot compel a person to do something that is not required under law.²⁸ Other claims against the State that are protected under the Constitution include the right to movement, association and peaceful assembly

21 PIP above n10 at 5.

22 Nizamuddin Siddiqui above n15.

23 Articles 141 and 142, Constitution of Pakistan.

24 Article 41(2) provides for the appointment of the President through an electoral college consisting of members of both houses of parliament and the provincial legislative assemblies.

25 Article 91.

26 Article 4 (1), Part I Introductory, Constitution of Pakistan.

27 Part I Introductory and Article 9, Chapter 1, Part II Fundamental Rights and Principles of Policy, Constitution of Pakistan.

28 Article 4 (2).

subject to reasonable restrictions imposed by law for preservation of sovereignty, integrity, public order and morality.²⁹ Freedom of speech and expression, including freedom of the press, though protected, can be restricted through law for upholding the glory of Islam for safeguarding national security, public order, morality and for preventing the commission and incitement of offence.³⁰

Constitutional protections afforded to persons within the criminal justice system include the right to legal representation and defence³¹ and procedural safeguards during detention and arrest.³² The same, however, can be waived in case of preventive detention.³³ Among other safeguards like the right against self-incrimination and double jeopardy,³⁴ the Constitution prohibits retroactive application of penal law (ex post facto penal law),³⁵ violation of dignity and privacy³⁶ and torture to exact evidence.³⁷

The Constitution seeks to protect the rights of religious minorities to preserve, practice and profess their religion³⁸ within a predominantly Islamic polity. Sex discrimination is expressly prohibited although the state is authorized to take affirmative action to further gender equality and the rights of women.³⁹

The State is forbidden from making laws that violate or abridge fundamental rights recognized by the Constitution.⁴⁰ At the same time, the Constitution itself provides for the suspension of these rights⁴¹

during the invocation of an emergency.⁴² Again, fundamental rights have been inoperative during periods of suspension of the Constitution.

In addition to guaranteeing fundamental rights, the Constitution in Chapter 2 enunciates principles of policy for the State and its agencies to observe. These include, inter alia, measures to secure for all citizens basic amenities, livelihood and social security. The application of these principles is subject to availability of resources.⁴³ Further, no action can be instituted against the state for non-compliance, as these principles are non-justiciable.⁴⁴

2.1.2 Religious law

Islamic law or the Shariat finds its application in the substantive as well as the procedural aspects of the law. The Constitution itself requires all laws to be brought in conformity with Islamic injunctions.⁴⁵

Islamization of law is said to have formally started in 1979 with the introduction of a new legal code and the setting up of the Federal Shariat Court to hear appeals from cases arising from the new code. The promulgation of the Prohibition (Enforcement of Hadd) Order IV of 1979 was seen as an attempt to harmonise penal provisions with Islamic injunctions.

The Hadd Order contains four ordinances dealing with offences against (1) property, (2) adultery (zina) and rape (zina-bil-jabr), (3) qazf (false accusation of zina) and (4) prohibition of intoxicants. These ordinances define offences, lay down procedure and evidentiary standards and prescribe penalties with respect to the above acts in accordance with Islamic concepts and principles. Under these

29 Article 17.

30 Article 19.

31 Article 10 (1), Chapter 1 Part II Fundamental Rights and Principles of Policy, Constitution of Pakistan.

32 Article 10 (2).

33 Article 10 (3).

34 Article 13.

35 Article 12.

36 Article 14(1).

37 Article 14 (2).

38 Articles 20, 21 and 22.

39 Articles 25 and 26.

40 Article 8(2).

41 Article 8 (5).

42 Article 233 (2) Part X Emergency Provisions, Constitution of Pakistan.

43 Article 29 (2) part II, Constitution of Pakistan.

44 Article 30 (2).

45 Article 227 (1) Part IX Islamic Provisions, Constitution of Pakistan.

ordinances, an offender is held liable to hadd⁴⁶ if the offence is proved with strict evidentiary requirements⁴⁷ or to tazir⁴⁸ if the Court is satisfied that the offence stands proved on the basis of proof on record but is not in accordance with strict evidentiary standards as required for hadd. Punishments for offences liable to hadd are more stringent as compared to punishment for offences liable to tazir. Punishments provided under the ordinances include flogging,⁴⁹ imprisonment and fines and stoning to death, or capital punishment for more serious offences. Further, execution of hadd penalties requires conviction to be confirmed by a Court of appeal,⁵⁰ the highest appellate forum being the Federal Shariat Court. Hudood convictions have been rare because of the difficulty in satisfying evidentiary norms. It is believed that the Hadd order was intended to create a normative code for Muslims rather than influence the penal system.⁵¹

The Enforcement of Shari'ah Act, 1991⁵² was aimed at instilling Islamic values into the legislative and judicial regime. The Act proclaims the supremacy of injunctions of Islam as laid in the Quran and Sunnah over other laws⁵³ and requires statutes to be interpreted in conformity with Islamic provisions.⁵⁴ The Act orders all Muslim citizens to observe the Shari'at and act accordingly.⁵⁵ Among other

declaratory provisions, the Act directs the state to introduce the Shariat in education and teaching⁵⁶, adopt Islamic principles in governance⁵⁷, promote Islamic values through mass media⁵⁸ and enact a range of legislative and administrative measures to ensure compliance with the Shari'at.⁵⁹

2.1.3 Courts

The judiciary, which comprises the district Courts exercising civil and criminal jurisdiction, special Courts and tribunals, High Courts and the Supreme Court, is responsible for the enforcement of legal and fundamental rights.⁶⁰ At the district level, civil judges and the Court of District Judge decide civil cases. Criminal cases are triable by Courts of Magistrates or the Sessions Court depending on the offence and the punishment.⁶¹ Special Courts and tribunals have been set up under various statutes to hear specialized matters pertaining to labour, traffic, insurance, narcotics etc.

Appeals against orders of civil and criminal Courts lie before the High Court of that province. The High Courts exercise original jurisdiction in matters delineated in the Constitution, which include cases involving enforcement of fundamental rights⁶² and under various statutes. The High Courts have regulatory and supervisory powers over subordinate civil and criminal Courts in their territorial jurisdiction.

The Supreme Court, seated at Islamabad is the highest judicial authority. The Court exercises original⁶³, appellate⁶⁴ and advisory jurisdiction.⁶⁵

46 Hadd means punishment ordained by the Holy Quran or Sunnah; See Section 2(f) Prohibition (Enforcement of Hadd) Order, 1979 (P.O. IV of 1979).

47 Ordinarily, proof required to establish liability to hadd is confession by the accused of commission of offence before the Court and evidence by muslim adult males, (number of witnesses specified in each of the four ordinances) who in the opinion of the Court, fulfil the requirement of 'tazkiyah al-shuhood' that they are truthful persons and abstain from major sins who have witnessed the accused committing the offence. See Section 9 Prohibition (Enforcement of Hadd) Order, 1979 (P.O. IV of 1979).

48 Tazir means any punishment other than Hadd; See Section 2(o) Prohibition (Enforcement of Hadd) Order, 1979 (P.O. IV of 1979).

49 According to the Abolition of the Punishment of Whipping Act, 1996, whipping can be inflicted as a punishment for hadd offences only.

50 See Proviso to Section 8, Prohibition (Enforcement of Hadd) Order, 1979 (P.O. IV of 1979).

51 Interview with SM Zafar, Senior Advocate, (October 2004)(Country Visit Notes on file with Unit)

52 Act X of 1991.

53 Section 3, the Enforcement of Shar'iah Act, 1991.

54 Section 4.

55 Section 5.

56 Section 6 and 7.

57 Section 8.

58 Section 9.

59 Sections 12 to 17.

60 Article 175 (1) Part VII The Judicature, Constitution of Pakistan.

61 Cases punishable by death or arising out of Enforcement of Hadd Order can only be tried by Court of Sessions. See <http://www.infopak.gov.pk/public/govt/judiciary.htm>.

62 Article 199, Constitution of Pakistan.

63 Article 184. The Supreme Court, to the exclusion of other Courts, has the jurisdiction to decide cases involving disputes between governments.

64 Article 185.

65 Article 186.

The Supreme Court has the power to make any appropriate order for the enforcement of fundamental rights.⁶⁶ Decisions of the Supreme Court are final and binding.⁶⁷

The Federal Shariat Court adjudicates over and hears appeals from cases involving the Enforcement of Hadd Order. The Court may examine and decide whether any law or provision is contrary to Islamic injunctions as contained in the Quran and the Sunnah. Laws declared to be inconsistent with Islam are required to be amended.

Another institution responsible for checking maladministration in government bodies is the Ombudsman or Wafaqi Mohtasib.⁶⁸ The Office of the Mohtasib is based on the Islamic concept of 'hisab' or accountability in public dealings. The Ombudsman investigates complaints made by aggrieved individuals against acts or omissions of public agencies and has the power to direct remedial measures, order disciplinary and award compensation. Procedural powers exercised by the Ombudsman are similar to powers conferred on civil Courts.⁶⁹

Overall, the legal system in Pakistan is based on English common law, with provisions to accommodate Islamic law. The criminal legal system is administered through the Pakistan Penal Code 1860, the Code of Criminal Procedure, 1898, in addition to other criminal acts, ordinances and the Hadd provisions. The law of evidence was revised in 1984 to accommodate Islamic standards and introduced as the Qanun-E- Shahadat Order, 1984.⁷⁰

66 Article 184(2) and (3).

67 Article 189, Part VII Chapter 2, Constitution of Pakistan
"Any decision of the Supreme Court shall, to the extent that it decides a question of law or is based upon or enunciates a principle of law, be binding on all other Courts in Pakistan."

68 See Establishment of the Office of Wafaqi Mohtasib (Ombudsman) Order, 1983 (P.O. No. 1 of 1983).

69 Ibid

70 The Qanun - E- Shahadat Order, 1984 (P.O No. X of 1984).

2.2 Drug Use and HIV/AIDS Harm Reduction Law

2.2.1 General penal provisions

Aiding and instigating the commission of an offence is punishable⁷¹ under the Penal Code as also criminal conspiracy.⁷² The offence abetted may not only be punishable under the Penal Code but under any other special or local law.⁷³

Sexual offences are punishable under religious law. The offence of Zina⁷⁴ ordinance, VII, 1979 makes willful sexual intercourse between a man and a woman, not married to each other, punishable. Like under other Hudood ordinances, Zina is liable to Hadd⁷⁵ or tazir. Non-consensual penetrative sex is punishable as Zina-Bil-Jabr.⁷⁶ Islamic legal provisions thus render all consensual adult sex outside marriage – whether pre-marital, extra-marital and/or paid, illegal. Zina offences are gender neutral i.e. women are also liable to punishment.

2.2.2 Drug use

According to Islamic legal scholars, prohibition on alcohol and other mind altering substances dates back to the time of the Prophet, who declared sale, serving and consumption of Khamr (literally referring to fermented juice of grapes, barley, dates or similar things and includes all

71 Section 107 defines abetment. Section 109 lays down punishment for abetment. See Chapter V, Pakistan Penal Code.

72 Section 120 A, Pakistan Penal Code defines criminal conspiracy to mean an agreement between two or more persons to do or cause to be done an illegal act or an act, which is not illegal by illegal means. Punishment for criminal conspiracy is contained in Section 120B.

73 Section 40, Pakistan Penal Code. The definition of offence, which is otherwise limited to act or omission under the Penal Code, has been widened to include acts punishable under local or special laws for the purposes of abetment provisions under Chapter V.

74 The offence of Zina is said to have been committed when a man and a woman, not validly married to each other willfully have penetrative sexual intercourse. See Section 4, Offence of Zina, Ordinance VII of 1979.

75 Proof required for Zina or Zina-bil-Jabr liable to Hadd is confession by the accused and at least four, muslim, adult, male eye witnesses to the commission of the offence. See section 8, Offence of Zina, Ordinance VII of 1979.

76 See Section 6.

intoxicants whether liquid, solid or powder) to be haram (prohibited).⁷⁷ Islamic jurists maintain that the Quran forbids intoxicants because their consumption impairs reasoning, intellect and decision-making and leads one towards an unethical and essentially un-Islamic way of life. Consequentially, a person using cannabis, hashish or similar substances was considered 'kafir' or one who loses faith.⁷⁸

Religious condemnation of alcohol and drugs is codified in the Hudood Ordinance on Prohibition.⁷⁹ The Order prohibits intoxicants,⁸⁰ including sale, import, export, trafficking and possession. Drinking is illegal and attracts punishments ordained by Shariat (Hadd)⁸¹ or by Court (Tazir).⁸² Drinking not only means consumption of alcohol but has been broadly defined to mean intentionally taking an intoxicant by any means whatsoever, whether such taking causes intoxication.⁸³ Drug use, orally or through intravenous injection, is prohibited and punishable under the Hadd Order.

Repeat offenders face additional jail sentence.⁸⁴ Attempt to commit an offence under the Order is punishable.⁸⁵ Punishment for abetment of an offence under the Order is to be awarded by the Court in accordance with Penal Code provisions.⁸⁶

77 Prof. Dr. Anis Ahmad "The Islamic Injunctions on Drugs: A universal approach" (UNODC Publication Draft).

78 Ibid

79 See Prohibition (Enforcement of Hadd) Order, 1979 (P.O. IV of 1979).

80 Section 2 (g) defines intoxicant "to mean an article specified in the Schedule and includes intoxicating liquor and other article or any substance, which the provincial government may, by notification in the official gazette, declare to be an intoxicant for the purposes of the order". Articles specified in the schedule include Bhang, Ganja, Charas, Opium and its derivatives, Coca leaf and derivatives and Hashish. Psychotropic substances, are however, not mentioned Use of Psychotropic medicines for non-medical purposes and without a prescription from qualified medical practitioner is an offense. Pakistan is signatory to all UN conventions.

81 Section 8, Prohibition (Enforcement of Hadd) Order 1979.

82 Section 11.

83 Section 6.

84 Section 24.

85 Section 25.

86 Section 26.

This raises questions about the legality of existing needle syringe exchange programs with IDUs in Pakistan, which could be construed as abetment of offence under Section 6 of Prohibition (Enforcement of Hadd) Order 1979.

The Order provides for the appointment of a Prohibition Officer by provincial governments, to exercise administrative and investigative powers under the same.⁸⁷ Rule-making powers are delegated to provincial governments.⁸⁸ Among other things, rules may be made for issuing licenses for medicinal, scientific and industrial use of intoxicants. In what appears to be recognition of drug maintenance therapy, the Prohibition (Enforcement of Hadd) Rules 1981, permit the supply of opium tablets to a person in respect of any institution for medicinal purposes.⁸⁹ Further, opium may be sold to an addict on presentation of a prescription card issued by a medical officer stating that the addict will suffer from serious illness causing apprehension of death.⁹⁰ The Shariat itself tolerates the use of a prohibited substance in order to save life.⁹¹

Such provisions provide scope for the recognition and inclusion of drug substitution/maintenance within the exception carved out in law for medical use of prohibited drugs.

The Control of Narcotic Substances Act (CNSA), 1997 is the secular legislation on narcotics. It was introduced in order to:

- ◆ Control production, processing and trafficking of narcotics and;
- ◆ Regulate treatment and rehabilitation of drug users

87 Sections 21, 22 and 23.

88 Section 31.

89 Rule 28, Islamabad Capital Territory Prohibition Rules 1981. Similar provisions are contained in Prohibition rules issued by Baluchistan, Punjab, North West Frontier and Sind provinces.

90 Rule 29, Islamabad Capital Territory Prohibition Rules 1981. Similar provisions are contained in Prohibition rules issued by Baluchistan, Punjab, North West Frontier and Sind provinces

91 Prof Dr. Anis Ahmad above n77.

The Anti Narcotics Force (ANF) Act, 1997 supplements the CNSA by providing for the establishment of a force for undertaking and overseeing investigation of narcotics crime. The Control of Narcotic Substances (Regulations of Drugs of Abuse, Controlled Chemicals, Equipment and Material)⁹² and Disposal of Vehicles and other articles (Involved in Narcotic Cases) Rules were introduced in 2001 to give effect to regulatory provisions under the CNSA.

The CNSA and the ANF legislations have been extended to FATA, other provincially administered tribal areas, Azad Jammu and Kashmir and Northern Areas to strengthen law enforcement in areas with heavy narcotics activity.⁹³

(a) *Nature and classification of prohibited substances*

The CNSA deals with illicit narcotic and psychotropic substances. Narcotic drugs is defined to include coca leaf, cannabis, opium, poppy straw, heroin and other manufactured drugs.⁹⁴ Psychotropic substances⁹⁵ have been enlisted in the Schedule to the CNSA, which expressly mentions buprenorphine, a commonly used pharmacological drug in oral maintenance therapy for injecting users. The CNSA also defines precursor chemicals as controlled substances.⁹⁶

(b) *Offences and penalties*

The CNSA prohibits the following activities in relation to narcotics and psychotropic substances:

- ◆ Cultivation with the exception of medical, scientific or industrial purposes and
- ◆ with a license⁹⁷
- ◆ Production
- ◆ Manufacture⁹⁸
- ◆ Extraction
- ◆ Preparation
- ◆ Possession
- ◆ Sale and purchase
- ◆ Distribution and delivery except for medical, scientific and industrial purposes

in accordance with prescribed conditions⁹⁹

- ◆ Import or Export¹⁰⁰
- ◆ Trafficking or financing trafficking¹⁰¹
- ◆ Owning, managing and operating premises, equipment for manufacture or
- ◆ production except with a license¹⁰²
- ◆ Possession, use etc of assets acquired from commission of offences.¹⁰³

Importantly, use or consumption of narcotics and/or psychotropic drugs is not an offence under the CNSA.¹⁰⁴ Possession of prohibited substances, which is another activity that drug users may be arrested for, is, however, punishable. Judicial interpretation suggests that possession has been used in a wider sense so as to include transport, despatch and delivery¹⁰⁵ thereby implying that the offence is targeted primarily at traffickers and not drug users.

Penalties for the above offences depend only on the quantity found.¹⁰⁶ Broadly, there are three levels of penalties. Firstly, if the quantity of illicit

92 Control of Narcotic Substances (Regulations of Drugs of Abuse, Controlled Chemicals, Equipment and Materials) Rules, 2001

93 Ministry of Narcotics Control, Government of Pakistan "Country Profile" available at www.diplomatie.fr/routesdeladrogue/textes/pakistan.pdf.

94 Section 2(s), Control of Narcotic Substances (Regulations of Drugs of Abuse, Controlled Chemicals, Equipment and Materials) Rules, 2001. Manufactured drugs are defined in sec 2(q).

95 Section 2(za); See Schedule.

96 Section 2 (k): "Controlled substance means any substance which may be used for the production or manufacture of narcotic drugs or psychotropic substance".

97 Sections 4 and 5.

98 Defined under section 2(p) of the CNSA to mean all processes for obtaining, refining, transforming, making and preparing such drugs and substances.

99 Section 6.

100 Section 7.

101 Section 8.

102 Sections 10 and 11.

103 Sections 12 and 13.

104 However, drug use, as such, is forbidden under Islamic law. See 2(g) Prohibition (Enforcement of Hadd) Order, 1979.

105 PLD 2002 Quetta 58

106 Section 9, CNSA.

substance found is less than 100 grams, the maximum punishment is 2 years imprisonment or fine or both.¹⁰⁷ Users found with lesser quantities for personal consumption would be liable under this provision. A second category of penal measures i.e. imprisonment extending up to seven years and fine for quantities above hundred grams but not exceeding one kilogram.¹⁰⁸ The death penalty or life imprisonment in addition to fine up to one million rupees can be imposed in case the quantities involved exceed the above.¹⁰⁹

There is no distinction in penalties for soft and hard drugs. A person found with 100 grams of ganja will be awarded the same punishment as someone carrying 100 grams of heroin, even though heroin is far more hazardous than cannabis.

The following acts if committed in relation to any of the offences delineated under the Act, within or outside Pakistan,¹¹⁰ are also punishable with the same punishment as that provided for commission of the offence.¹¹¹

- ◆ Participation in
- ◆ Association with
- ◆ Conspiracy to commit
- ◆ Attempt to commit
- ◆ Aid
- ◆ Abetment
- ◆ Facilitation
- ◆ Incitement
- ◆ Inducement
- ◆ Counsel the commission

Since the CNSA does not punish drug use per se, provision of drug injection paraphernalia does not amount to abetment and hence is not objectionable under the Act. Methadone maintenance or oral buprenorphine substitution programs, since they involve giving/distributing illicit drugs, would be

in contravention of the CNSA, unless such therapy is recognized within the exception of supply for medical treatment.

(c) Powers and procedures

The CNSA directs search, investigation and arrests to be made with a warrant issued by a Special Court¹¹² or without a warrant in exceptional situations¹¹³ after recording reasons.¹¹⁴ In exercise of powers conferred under the Act, investigating officers can:

- ◆ Enter buildings or premises¹¹⁵
- ◆ Seize illicit substances¹¹⁶
- ◆ Confiscate materials, articles and documents, which may furnish evidence of
- ◆ commission of offence¹¹⁷
- ◆ Detain, search and arrest persons suspected of committing an offence¹¹⁸

Similar powers can be exercised with respect to offences committed in public places including shops and hotels¹¹⁹ and in conveyances.¹²⁰

Additionally, enforcement officials are authorized to call for information, summon any documents and examine any person for inquiry.¹²¹

Notwithstanding immunity afforded to government officers under the good faith provision¹²² officers guilty of conducting illegal searches and arrest without reasonable grounds are liable to

107 Section 9(a).

108 Section 9(b).

109 Section 9(c).

110 Section 14.

111 Section 15.

112 Section 20, CNSA.

113 Section 21 allows an authorized officer to enter, search, seize and arrest without a warrant if, in her/his opinion, an offence pertaining to a prohibited substance has been committed under the Act or where such substances are kept or concealed and a warrant cannot be obtained without affording an opportunity to the said offender to escape or destroy evidence.

114 Section 21(2).

115 Section 21(1).

116 Section 21(1).

117 Section 21(1).

118 Section 21(1).

119 Section 22.

120 Section 23.

121 Section 31.

122 Section 64.

prosecution and punishment.¹²³ The provision serves as a check on the otherwise unbridled powers conferred on law enforcement officials. However, the use of such safeguards is not known.

With respect to evidentiary requirements in trials, the CNSA creates a presumption of offence against a person, who fails to account satisfactorily for possession of:

- (1) Illicit substances
- (2) Equipment, apparatus or utensil adapted for the manufacture of drugs
- (3) Any materials undergoing transformation and residue left of materials from which prohibited substances are prepared¹²⁴

Documentary evidence standards have also been relaxed to some extent.¹²⁵ While the provisions appear to dilute standards of proof by shifting the burden of proof on to the accused, Courts have held that section 29 does not absolve the prosecution of its primary duty to prove its case beyond reasonable doubt.¹²⁶

Offences under the CNSA are non-bailable i.e. bail is at the sole discretion of the Court and is ordinarily refused unless the Court opines that the case is fit and against a substantial amount of security.¹²⁷ Also, bail cannot be granted for offences punishable with death under the CNSA or any other narcotics law.¹²⁸

All offences under the CNSA are triable exclusively by Special Courts.¹²⁹ Offences punishable with imprisonment of two years or less are triable by Judicial Magistrate of First Class whereas other offences are triable by a Sessions or Additional

Sessions Court.¹³⁰ Thus far, six special Courts have been set up.¹³¹ The same has reportedly resulted in speeding up disposal of cases and securing higher convictions of drug offenders.¹³² The Federal Government may also appoint Special Prosecutors to try cases under the Act.¹³³

(d) *Statutory structure for implementation*

The Anti-Narcotics Force (ANF) is the principal agency responsible for enforcement of the Narcotics Control Act.¹³⁴ The ANF was established in 1995 under the ANF ordinance, later passed as an Act. Before that, the Pakistan Narcotics Control Board (PNCB) in co-ordination with the Anti-Narcotics Task Force implemented anti-narcotics activity. In 1989, a Narcotics Control Division (NCD) was created within the Ministry of Interior to exclusively handle narcotics matters and the ANF functioned as an attached department. A separate Ministry for Narcotics Control was formed in 2002 with the ANF designated as the lead agency for enforcement.¹³⁵

The ANF is headed by a Director General, an appointee of the Federal Government.¹³⁶ The Federal Government also appoints other members of the Force.¹³⁷ The Director General exercises powers similar to that of the Inspector General of Police.¹³⁸ Other officials of the Force have powers and liabilities as those of a police officer including powers to conduct search, confiscate goods and assets,

123 Section 26 lays down punishment for vexatious entry, search, seizure and arrest operations conducted by authorized officials.

124 Section 29.

125 Section 30 CNSA.

126 PLD 2002 Quetta 58 + 2002 MLD 1983 (Pesh)

127 Section 51 (2) CNSA.

128 Section 51 (1).

129 Section 45.

130 Section 46(2) and (3).

131 Interview with Ismail Hassan Niazi, Senior Joint Secretary, Ministry of Narcotics Control, Government of Pakistan (October 2004)(Country visit notes on file with the Unit).

132 See Bureau for International Narcotics and Law Enforcement Affairs "International Narcotics Control Strategy Report 2001: Pakistan" (March 2002), available at <http://www.state.gov/g/inl/rls/ncrpt/2001/rpt/>.

133 Section 50, CNSA.

134 According to its Charter of Duties, the ANF is required to inquire, investigate and prosecute narcotics dealers, co-ordinate enforcement activity, implement demand reduction strategies and liaise with international drug control agencies. See <http://www.pakistan.gov.pk/narcotics-division/publications/charter.jsp>.

135 Section 5(a), Anti Narcotics Force Act, 1997.

136 Section 3(2).

137 Ibid.

138 Section 4(2).

detain and make arrests, inquire and investigate offences.¹³⁹ Because of shortage of personnel in the ANF, investigational powers have been delegated to Excise, Customs and Police Departments and other paramilitary agencies.¹⁴⁰ The Federal government has the power to enact rules vis-à-vis functioning of the Force under the ANF Act.¹⁴¹

The Policy Review Board, a high-level decision-making and monitoring body, having ministerial representation at the federal level, meets annually to review narcotics control activity.¹⁴² Besides, the National Interdiction Committee comprising civil servants and representatives from the Armed Forces oversees and evaluates enforcement efforts aimed at curbing drug trafficking.

(e) Treatment and rehabilitation of users

The CNSA defines an addict to mean drug dependent as well as habitual users.¹⁴³ The provincial governments are required to register all drug users within their respective jurisdiction.¹⁴⁴ Users are required to carry their registration card at all times for presentation before authorities.¹⁴⁵ The financial burden of treatment, care and follow up of users is shared between the provincial and federal governments; while the former are bound to set up service centres,¹⁴⁶ the cost of one-time detoxification is to be borne by the Federal Government.¹⁴⁷ There is no provision in the Act that enables the government to assist, support or regulate non-governmental drug treatment set-ups.

Registration and compulsory detoxification provisions have, however, not been implemented. Even on paper, users who relapse are left out of government-sponsored treatment, which is

mandated only once. Facilities for detoxification both in the government and outside were found to be inadequate and way short of what is required to fulfill the government's statutory obligation.

Under the CNSA, the Federal Government may establish a National Fund for Control of Drug Abuse to allocate resources for drug supply and demand reduction activities including treatment and rehabilitation of drug users.¹⁴⁸ According to expert sources, the fund is envisaged to receive:

- 1) Grants from the Federal or the Provincial government
- 2) Sale proceeds of the unserviceable commodities and vehicles provided by donors for narcotics control
- 3) Grants by any person or institutions
- 4) Income from the investment of the amounts credited to the fund

Additionally, proceeds from sale of seized assets (acquired from drug related crimes) are reportedly transferred to the National Fund.¹⁴⁹ The proposed objective of the fund is to meet expenditure incurred over controlling trafficking in narcotics drugs and psychotropic substances, for treatment and rehabilitation of drug users and for incidental purposes, as may be specified by Federal Government.¹⁵⁰

Elimination of smuggling, trade and supply of narcotics appear to have been the predominant concerns for lawmakers at the time of framing the CNSA, possibly because Pakistan is seen as a transit for illicit drugs cultivated and manufactured in Afghanistan en route to international markets. Concerns about drug trafficking have overshadowed domestic problems of drug use, treatment and rehabilitation of users, which have been given a marginal treatment in the CNSA.

139 Section 6(1).

140 See Country Profile above n93.

141 Section 17, ANF Act.

142 Pakistan Narcotics Division, <http://www.pakistan.gov.pk/narcotics-division/publications/prb.jsp>.

143 Section 2(a) CNSA.

144 Section 52(1).

145 Section 52(3).

146 Section 53.

147 Section 52(2).

148 Section 54.

149 Feedback on overview and findings of the review from ANF, at the Regional Tripartite Review Meeting, Colombo, Sri Lanka, 30-31 March 2006

150 Communication with Dr. Nadeem-Ur-Rehman, Programme Coordinator, UNODC, Country Office for Pakistan

(f) *Inconsistent legal approach to drug use*

The Prohibition (Enforcement of Hadd) Order makes use of intoxicants a serious offence. The CNSA, on the other hand, does not criminalise drug users. Instead, the Act obligates the government to identify, register, treat and restore drug users back to the community. The two statutes are at variance vis-à-vis the legal treatment accorded to persons with drug related problems. Whether an addict in contact with authorities finds himself in prison for violating the Hadd Order or is able to seek treatment at a centre established under the CNSA remains unclear.

(g) *Juveniles using drugs*

Minor drug users are juvenile offenders, punishable under the Hadd (Prohibition) Order. Those caught in possession of illicit drugs are additionally liable under the CNSA. Such children are to be tried in separate Courts set up under the Juvenile Justice System Ordinance, 2000 and may be placed in borstal institutions.¹⁵¹ No specific provision has been made for drug dependent children either in the Ordinance or the rules enacted thereunder,¹⁵² besides medical treatment for juveniles suffering from serious illnesses including TB, Hepatitis B and C, and HIV/AIDS.¹⁵³

2.3 Drug Use and HIV/AIDS Harm Reduction Policy

2.3.1 Drug use

The Drug Abuse Control Master Plan¹⁵⁴ enunciates objectives and implementation strategies that the

government proposes to use to address the domestic drug problem. The stated objectives are two-fold: aimed at achieving drug demand and supply reduction. The plan seeks to lessen the incidence of drug abuse through preventive, educational, harm reduction, treatment and rehabilitative measures¹⁵⁵ and restrict availability of illicit substances through specific enforcement activities.¹⁵⁶

The plan adopts a public health approach in contrast to a punitive model towards drug use. The document acknowledges harm reduction and treatment as integral components of a drug demand reduction programme. It proposes to make available drug-related services through government and non-governmental set-ups. The Plan explores various medical, social and economic models in the context of treatment and rehabilitation including programs for harm reduction for heroin dependent users and injecting users, home-based rehabilitation, narcotics anonymous and self-help structures, therapeutic communities and income generation.¹⁵⁷

From a law enforcement perspective, the plan calls for differential treatment of users and traffickers, recommending harsh penalties for drug pushers and suppliers while proposing treatment and social support for drug users. Significantly, it recognises the widespread nature of drug problem in jails and recommends among other measures, establishment of prison based treatment interventions.¹⁵⁸

Even though most of the targets and objectives remained unaccomplished at the end of 2003, the significance of the National Plan lies in the pragmatic approach that it adopted towards the problem of drug abuse. It recognizes the need for ensuring the availability of a continuum of services for users including services that avert immediate harms of injection drug use instead of concentrating on elimination of drugs only. The framework outlined in the document creates

151 Section 2(a) of the Juvenile Justice System Ordinance 2000 defines such institution to mean a place where child offenders may be detained and given education and training for their mental, moral and psychological development.

152 Juvenile Justice Rules, 2001 (Islamabad Territory).

153 Section 6(6), Juvenile Justice System Ordinance, 2000 and Rule 13(4), Juvenile Justice Rules, 2001 (Islamabad Territory).

154 Drug Abuse Control Master Plan for Pakistan above n2 (Hereinafter Master Plan). The Plan was prepared with the assistance of the United Nations International Drug Control Programme. The Plan was approved by the Government in February 1999. Anecdotal reports indicate that extension of the Plan period that expired in June 2003 is under consideration and has not been approved by the Cabinet till date.

155 Master plan, Objectives 1 and 2.

156 Master Plan Objectives 3 and 4.

157 Master plan at 23.

158 Master plan, Strategy 2.4 at 24.

a permissive policy environment for some of the controversial interventions such as needle syringe exchange that the HIV/AIDS epidemic calls for in the context of drug use.

2.3.2 HIV/AIDS

Shortly after the detection of the first case of HIV/AIDS in 1987, the government set up a Federal Committee that focused mostly on clinical case detection. In 1988, HIV/AIDS was declared a notifiable disease.¹⁵⁹ The National AIDS Prevention and Control Program (NAPCP) handled by the Ministry of Health was integrated into the Social Action Programme¹⁶⁰ in 1994 with an expanded mandate encompassing information on HIV prevention and blood safety. The current enhanced National AIDS Control Programme (NACP) has been operational since 2003. This expands and builds on the original NAPCP. The NACP is presently implemented at the federal and provincial levels with over 80% domestic/governmental funding.¹⁶¹

A National HIV/AIDS Strategic Framework was formulated in 2000 outlining priority areas for programme implementation. These include harm reduction among high-risk groups like sex workers, MSM and IDUs, general awareness, management of sexually transmitted infections, surveillance and research, and care and support.¹⁶²

Objectives set out in the strategic plan were elaborated in the Enhanced HIV/AIDS Control Program and issued as a Program Implementation Plan (PIP) for the period 2003 to 2008. The same is being funded by the World Bank with additional support from CIDA and DFID and implemented through provincial HIV/AIDS control bodies and NGOs.¹⁶³ The Plan is set out against the present

epidemiological scenario in Pakistan, which is reportedly one of low HIV prevalence both among general population as well as vulnerable groups. At the same time, practices that entail high risk of transmission such as unprotected sex and injection sharing are well established among sex workers, MSM and IDUs. In this context, the AIDS program concentrates on prevention, as put forward in its goal - "to prevent HIV from becoming established in vulnerable populations and spreading to the general adult population, while avoiding stigmatization of vulnerable populations."

The PIP comprises four components, the first being expansion of interventions for vulnerable populations.¹⁶⁴ It proposes to reach out to these groups with a range of harm reduction information and equipment such as condoms, lubricants, clean needles and disinfectants, STI and drug treatment, voluntary counselling and testing and referral services¹⁶⁵ through NGOs.¹⁶⁶ The document makes note of socio-cultural and religious inhibitions that impede interventions and proposes to influence the same through advocacy measures.¹⁶⁷

The implementation Plan thus provides a definite mandate for harm reduction interventions with IDUs and their sexual partners.

3. DRUG USE AND HIV/AIDS HARM REDUCTION PRACTICES

3.1 Prevention

3.1.1 Drug use

Prevention of drug abuse has been pursued within the larger framework of demand reduction programs. Under the UNODC funded Integrated Drug Demand Reduction Project, attempts were made to introduce drug abuse prevention education

159 "Reach beyond Borders" above n16.

160 A World Bank-supported programme intended to increase the government's spending in the social sector.

161 PIP above n10, Executive summary at 5.

162 The National HIV/AIDS Strategic Framework of Pakistan at 15.

163 Communication with Dr. Nadeem-Ur-Rehman above n149.

164 PIP above n10 at 5.

165 PIP *ibid* annex 1 at 54.

166 PIP above n10 at 45

167 PIP annex 1, at 54.

in schools, workplaces and prisons¹⁶⁸ and were reportedly successful in mobilizing communities in anti-drug campaigns.

The Drug Abuse Prevention Resource Centre (DAPRC) an autonomous body set up in 1989 was the focal governmental agency for drug prevention efforts. Specifically, the DAPRC was responsible for creating awareness, developing educational material and public media messages, training community workers on the problem menace of drug addiction and organising anti-narcotics campaigns. In the recent past, drug abuse prevention work undertaken by DAPRC has been impaired by lack of sustained funding and the Government is now increasingly turning to NGOs for continuing drug education activity.¹⁶⁹

3.1.2 HIV/AIDS

(a) *Information education and communication/behaviour change communication*

As Pakistan is still in a low HIV/AIDS prevalence phase, information, education and behaviour change has been identified as the frontline of prevention programming. The Government has committed itself to providing adequate information on HIV transmission and means of protection to all segments of the population with a specific emphasis on youth and vulnerable communities.¹⁷⁰

It may be pointed out that although the NACP clearly affirms harm reduction information as the need of the hour, including information on condom use, religious laws do not support IEC curricula that in any way refer to sex outside marriage,¹⁷¹ which is a punishable offence.¹⁷² Similarly, behaviour change messages urging IDUs to use

sterile injection equipment can be questioned on grounds of aiding and abetting drug use. Though no formal objections to HIV/AIDS IEC material were reported, NACP officials did express the compelling need to co-opt religious leaders and policy makers to avoid social and religious disapproval of HIV prevention public messages.¹⁷³ Some also feel that a candid discussion on sexual behaviours, which is essential for enabling individuals to assess risks and susceptibility to HIV/AIDS, cannot take place in a restrictive legal, social and cultural environment.¹⁷⁴

(b) *Condom promotion*

Socio-religious and legal restrictions on non-marital sexual activity have not diluted the government's response towards HIV/AIDS prevention. Under the enhanced HIV/AIDS Control Program Implementation Plan, condom education and distribution has been identified as an integral part of the service package for sex workers, IDUs and MSM.¹⁷⁵ Besides condoms, lubricants have also been included in the set of prevention tools for MSM.¹⁷⁶

Condom demonstration and supply is part and parcel of harm reduction services for IDUs and sexual partners.¹⁷⁷ NGOs have, however, found it difficult to reach sex workers with information and condoms.¹⁷⁸ Attempts have been made towards

168 Master Plan above n2 at 11.

169 Ibid.

170 PIP above n10 at 24.

171 For instance, section 9. Enforcement of Shar'iah Act 1991 forbids the publication and promotion of programs against or in derogation to the Shar'iah, including obscene material.

172 Offence of Zina, (Enforcement of Hudood) Ordinance (VII of 1979).

173 Interview with Dr. Asma Bokhari, National Programme Manager, NACP, National Institute of Health, Ministry of Health, Government of Pakistan (October 2004) (Country visit Notes on file with the Unit).

174 Interview with Dr. Nadeem-ur-Rehman, Programme Coordinator, UNODC Country Office for Pakistan (October 2004) (Country visit Notes on file with the Unit).

175 PIP above n10 Annex 1.

176 PIP ibid at 59.

177 "Pakistan Harm Reduction Experience Implementation Realities" based on implementation of DFID-funded: HIV/AIDS Prevention with Drug Harm Reduction in Pakistan (HAPDHRP) Project of Enhanced HIV/AIDS Control Programme of Government of Pakistan through Nai Zindagi, Dost Welfare Foundation, Caritas Pakistan Lahore, Al-Nijat Welfare Society and Marie Adelaide Habilitation Programme, Futures Group, HAPDHRP Project, August 2004. See also, Nai Zindagi brochure

178 Interview with Ahmad Bakhsh Awan, Nai Zindagi (October 2004) (Country Visit Notes on file with the Unit). Albeit sex workers in the Ali Park area of Lahore have expressed the need for primary

involvement of communities in HIV prevention projects. One such programme, involving sex workers as in social marketing of condoms is being run in the Serey Ghat red light area in Hyderabad in the Sindh Province and is said to have succeeded in building confidence of the target community itself despite fear of reprisal from law enforcement.¹⁷⁹

Condoms were hitherto supplied as a measure for prevention of pregnancies in the government run family planning programme. The AIDS control programme has taken on condom promotion for disease prevention in addition to its existing use as a contraceptive. Legal experts reason that neither religious law nor penal provisions on abetment prohibit condom promotion which is primarily a birth control measure and that the additional employment of condoms for AIDS prevention does not render condom provision illegal.¹⁸⁰ However, supplying condoms and lubricants to MSM for anal sex, as proposed under the Enhanced program of the NACP, would be open to legal challenge.¹⁸¹

(c) *Treatment for Sexually Transmitted Infections (STIs)*

The Government in its PIP has recognized STI treatment as a significant means for AIDS prevention and control.¹⁸² The PIP requires STI treatment to be offered to groups at higher risk of infection including sex workers, MSM and IDUs¹⁸³. Presently, Skin and STD departments in

tertiary hospitals are the only sites for receiving STI treatment.¹⁸⁴ The implementation plan seeks to make available STI detection, management and treatment through primary public health care institutions.¹⁸⁵ Outside government institutions, STI prevention and treatment services are provided at Drop in Centres for IDUs set up under harm reduction programs.¹⁸⁶ However, access for sex workers and MSM remains poor.

(d) *Voluntary Counselling and Testing (VCT)*

HIV counselling and testing services are neither available nor accessible in Pakistan. In the absence of counselling, anti-retroviral treatment and support structures for persons testing positive, NGOs were skeptical of encouraging/referring IDU clients to government hospitals for HIV testing.¹⁸⁷ These lacunae were sought to be addressed under the enhanced program. The PIP incorporates access to voluntary and confidential counselling and testing as a service delivery component for vulnerable groups.¹⁸⁸ No formal guidelines for setting up and running VCT centres have, however, been drawn till date.

(e) *Needle Syringe Exchange Programme (NSEP)*

Pakistan has been one of the first countries in the region to develop programmes for injecting drug use and HIV/AIDS epidemics by introducing needle syringe exchange for IDUs. Reports suggest that syringe exchange was started in Karachi as early as 1993 but was shut down in less than a year for want of support.¹⁸⁹ Years later, in 1999,

health care facilities and AIDS prevention, the NGO however declined for lack of capacity to work with sex workers. As IDUs are concentrated in the same area where sex workers are ghettoised, the NGO has to some extent been able to provide services to sex workers, who are sexual partners of IDUs. Sex workers too, reportedly refer their IDU partners for abscess management and drug treatment to the NGO's Drop In Centre.

179 "Pakistani sex workers come together to fight HIV/AIDS", Inter Press Service, 7 August 2004, posting on sex-work@eforums.healthdev.org

180 Interview with Ali Zafar and Hamid Shabbir Aazar, Advocates, Mandviwalla and Zafar Advocates, Lahore (October 2004) (Country Visit Notes on file with the Unit)

181 Anal sex is an offence under Section 377 of the Pakistan Penal Code. Supplying condoms to a man, with the intention that he has sex with another man, can be construed as abetment under section 107 of the same Code.

182 PIP, Pg 32

183 PIP, annex 1

184 PIP, Pg 32

185 PIP Pg 33

186 "Pakistan Harm Reduction Experience Implementation Realities" based on implementation of DFID-funded: HIV/AIDS Prevention with Drug Harm Reduction in Pakistan (HAPDHRP) Project of Enhanced HIV/AIDS Control Programme of Government of Pakistan through Nai Zindagi, Dost Welfare Foundation, Caritas Pakistan Lahore, Al-Nijat Welfare Society and Marie Adelaide Habilitation Programme, Futures Group, HAPDHRP Project (August 2004).

187 Interview with Dr. Simon Azariah, Project Director, HAPDHRP, Futures group Europe and Ahmad Bakhsh Awan, Nai Zindagi (October 2004)(Country Visit notes on file with the Unit)

188 PIP above n10 at 19.

189 "Pakistan Harm Reduction Experience Implementation Realities" above n183 at 3.

a situational assessment of street based IDUs in Lahore found zero HIV prevalence but a very high prevalence of Hepatitis C and established needle-sharing as routine and widespread. Nai Zindagi, a local NGO run by ex-users that conducted the Lahore assessment, initiated a pilot intervention for preventing transmission of HIV/AIDS and other blood borne diseases among IDUs through provision of sterile syringes and needles.¹⁹⁰ Although the harm reduction approach was influenced by the Amsterdam model of safe injecting havens, the project is said to have evolved on the basis of community needs.¹⁹¹

The pilot project was launched in 2000 with support from UNAIDS. At that stage, the ANF and the Narcotics Ministry did not, reportedly, object to the programme¹⁹² and later, together with the Ministry of Health, formally endorsed harm reduction as a drug treatment and HIV/AIDS prevention strategy.¹⁹³ The ANF and the NACP, Ministry of Health are presently partnering with the Futures Group on the DFID funded HIV/AIDS Prevention with Drug Harm Reduction in Pakistan to implement programs on a national scale.¹⁹⁴ The coming on board of the ANF, the foremost anti-narcotics agency, on to the harm reduction agenda in Pakistan is noteworthy and presents a significant lesson in drug use and HIV/AIDS harm reduction programming for the other countries in the SAARC region.

The NSEP that started in Lahore has over the years developed into a comprehensive drug and HIV/AIDS

programme. Yet, the crux of the program remains provision of safe injection paraphernalia to IDUs that includes cotton swabs, syringe and needle but does not include bleach or cookerries.¹⁹⁵ Besides, a range of other services such as drug and HIV related counselling, health care, wound dressing, abscess management and referral for advanced medical care, drug detoxification and rehabilitation are also offered to both injection and non-injection users. At the point of entry, clients are handed a registration card. Besides facilitating clinical monitoring and follow up, clients have reportedly found this informal registration method useful in averting on-street harassment.¹⁹⁶ Services are delivered at Drop in Centres (DIC) and through mobile vans. The DIC provides a safe space to users who walk in to the shelter to bathe, wash, rest, receive medical treatment, collect condoms, exchange clean needles for contaminated ones or just be.¹⁹⁷ Mobile vans equipped with medical supplies including disposable needles/syringes are strategically stationed at different locations to offer services to mobile drug injectors.¹⁹⁸ Outreach and peer driven strategies are central to the overall programme.

Interference and disruption of services by law enforcement was reported to be minor. Significantly, Nai Zindagi has used personal rapport/contacts within the establishment/authorities to forestall intrusions into its programs. Initial complaints from local residents were also said to have been effectively handled by the project staff.¹⁹⁹ IDUs on the street did mention being frisked, harassed and occasionally beaten by the police but no incidents of arrests under Shariat or narcotic laws were

190 Outreach to injecting drug users in Pakistan in UNAIDS Asian Harm Reduction Network, UNODC "Preventing HIV/AIDS among drug users: Case studies from Asia" Regional Task Force on Drug Use and HIV Vulnerability at 33.

191 Interview with Tariq Zafar, Nai Zindagi (October 2004)(Country Visit notes on file with the Unit).

192 Interviews with Dr. Simon Azariah, Futures Group and Dr. Nadeem-Ur-Rehman, UNODC, Country Office for Pakistan (October 2004)(Country Visit notes on file with the Unit).

193 Master Plan, National HIV/AIDS strategic framework and PIP. Interviews with Ismail Hasan Niazi, Senior Jt Secy, Ministry of Narcotics, GOP and Asma Bokhari, National Programme Manager, NACP, Ministry of Health, GOP.

194 "Pakistan Harm Reduction Experience Implementation Realities" above n183.

195 Interview with Ahmad Bakhsh Awan , Nai Zindagi, n178

196 Interviews with Ahmad Bakhsh Awan, Nai Zindagi and Dr. Simon Azariah, Futures Group, Europe. (October 2004)(Country Visit notes on file with the Unit)

197 One of the first DICs set up by Nai Zindagi was in Ali Park, Fort Road area of Lahore, a ghetto for marginalized IDUs.

198 One of the sites in Lahore where Nai Zindagi parks its mobile van for fixed hours during the day is the Lahore Hotel, an area known for furtive commercial drug activity and therefore having a significant presence of users. This strategic location of the van enables service providers to reach out to users from all over the city, who are otherwise dispersed and hard to reach.

199 Interview with Ahmad Bakhsh Awan above n185.

reported.²⁰⁰ The legality of NSEP has reportedly never been questioned.

Nai Zindagi's harm reduction intervention has had impacts at many levels. Specific indicators highlighting the success of the project in minimizing adverse health consequences of drug injection have been documented.²⁰¹ As a result of the intervention, health seeking among street injectors has improved and significant numbers of drug users are reported to have sought enrollment in detoxification and drug treatment centres.²⁰² The project has been emulated elsewhere in the country and NSEPs are running in Quetta, Peshawar and Karachi. A similar project is being established in Larakna after an alarming incidence of HIV/AIDS was detected among IDUs in 2003. NSEP is now a key constituent of the National AIDS strategy.

That NSEP is an effective strategy for containing HIV transmission among IDUs has largely remained unchallenged in Pakistan. Yet, some in the public health circles are beginning to point out that a critical evaluation of the needle syringe exchange (NSE) module from a health as well as drug harm perspective has never been done.²⁰³ Even on the HIV/AIDS front, there is some skepticism, including among supporters of harm reduction, about the efficacy of needle exchange alone in preventing the spread of HIV among IDUs once HIV/AIDS enters the pool of intravenous injectors.²⁰⁴ Experts feel that unless harm reduction is backed up by drug treatment, recovery and rehabilitation to enable drug users to lead drug free lives, the detrimental effects

of drugs on individuals and communities will be only marginally addressed.²⁰⁵

In terms of its legal status, the NSEP does not breach provisions under the CNSA. However, it could be viewed as being contrary to the religious edict against intoxicants as contained in the Prohibition (Enforcement of Hadd) Order 1979.

(f) Oral drug substitution

Pakistan is yet to introduce or even experiment with drug substitution programs. However, UNODC officials indicated that there was some talk within government circles of initiating a pilot oral substitution project.²⁰⁶ No other details regarding the pilot site, the substitute drug proposed to be offered, the sample size or the duration of the project were available. At the same time, an official from the Narcotics Ministry refuted the idea on the grounds that providing illicit drugs to injection users would be in contravention of the law.²⁰⁷ Although the CNSA and the Prohibition (Enforcement of Hadd) Order 1979 do not permit oral substitution therapy for drug users, such programs could be implemented lawfully if supply of methadone/buprenorphine is recognized as a medical necessity or for the purpose of treatment of drug dependents.

3.2 Treatment

3.2.1 Drug treatment and rehabilitation

Secondary sources suggest that there are nearly 73 drug treatment centres in the NGO, public and private sectors.²⁰⁸ All drug treatment centres in the public state sector are run by provincial governments, which are under a statutory obligation to establish such centres.²⁰⁹

200 Interaction with IDUs at the DIC in Ali Park, Lahore (October 2004)(Country Visit notes on file with the Unit)

201 Outreach to injecting drug users in Pakistan in "Preventing HIV/AIDS among drug users: Case studies from Asia" above n190 at 37, Table 2.

202 Ibid. See also Nai Zindagi "Taking it to the streets: A harm reduction programme for Pakistani Drug Users" in HIV/AIDS Prevention, Care and Support: Stories from the Community

203 Interview with Dr. Nadeem-Ur-Rehman, UNODC, Country Office for Pakistan, n174

204 Interview with Dr. Nadeem-Ur-Rehman, n174. According to latest surveillance, (unreleased) nearly 6% IDUs in Karachi are infected with HIV/AIDS.

205 Interview with Dr. Nadeem-Ur-Rehman, n174

206 Ibid.

207 Interview with Ismail Hassan Niazi, Senior Joint Secretary, Ministry of Narcotics, Government of Pakistan (October 2004)(Country Visit Notes on file with the Unit).

208 Communication with Dr. Nadeem-Ur-Rehman above n12.

209 Section 53, CNSA.

Most NGO-run facilities are limited to provision of basic detoxification without follow up or support for rehabilitation. A few, however, offer extended care encompassing medical, psychological and economic aspects of recovery.²¹⁰

The challenge before the government, non-government and donor agencies working in the field of drug dependency is that of scale, considering that a vast majority of Pakistan's 3.01 million drug dependent population is out of reach of services.²¹¹

Pakistan is also witnessing increasing drug use and addiction among children and the most affected are those marginalized and living in urban poverty. Glue sniffing is reported to be a common practice among children living on the streets in major the cosmopolitan cities of Pakistan. Some interventions have been initiated by NGOs²¹²

but these remain few and far between. Till date, no formal response has been developed by the government to address the problem of poverty and substance abuse among children.

3.2.2 HIV/AIDS

Services for people testing positive for HIV/AIDS are reported to be non-existent. Health care providers in both public hospitals as well as private medical settings do not have adequate knowledge or training on HIV/ADS management, treatment for opportunistic infections, anti-retroviral therapy and clinical care. AIDS programming continues to remain rooted in prevention. Some information about informal and formal organization of people living with HIV/AIDS is available but stigma and fear of discrimination is reported to dissuade PLHAs from approaching these support networks.²¹³ Although the NACP-enhanced AIDS Control Programme alludes to care and support for PLHAs,²¹⁴ no concrete steps have been taken yet towards making support services available to PLHAs institutionally or otherwise.

210 Nai Zindagi, for one, runs an intensive therapeutic centre at the outskirts of Lahore. Besides medical-social aid, economic opportunities in vocations like carpentry, leather goods and motor repair. See Outreach to injecting drug users in Pakistan in "Preventing HIV/AIDS among drug users. Case studies from Asia" above n190 at 36.

211 Highlights of the Findings of National Drug Abuse Assessment Study of Pakistan 2000/01, see <http://www.pakistan.gov.pk/narcotics-division/publications/findings.jsp>.

212 Project Smile is one such intervention for homeless /street based children in Lahore. The programme is run by Nai Zindagi with support from Aus AID/European Commission and provides primary health care, nutrition, information and education on risk reduction and referral for drug treatment to street based children including those dependent on drugs. Children are contacted through street

outreach and are encouraged to access the Drop In Centre in Ali Park for information and services. See PROJECT SMILE Brochure and interview with Dr Sayeed, Co-ordinator, Project Smile, Nai Zindagi (Country Visit Notes)

213 Ashfaq Yusufzai, "AIDS Patients in Pakistan launch fight for better treatment" posting on sea-aids@eforums.healthdev.org (Peshawar, 10 October 2004).

214 PIP above n10 at 43.

III. COUNTRY ANALYSIS – (G) SRI LANKA

Sri Lanka¹ is an island located in the Indian Ocean between Maldives, India and Indonesia. The population is approximately 20 million, and comprises Sinhalese, Sri Lankan Tamils, Indian Tamils, Moors, Burghers, Malays and other ethnic groups.² Sri Lanka is also diverse in its religious affiliations, including Buddhists, Hindus, Muslims and Christians.³ Following independence in 1948, there are primarily two groups, the Sri Lankan Sinhalese Buddhists and the Sri Lankan Tamil Hindus. The Sri Lankan Tamils occupy the North East of the island.

Conflicts arose and a separatist movement emerged under the leadership of the Liberation Tigers of Tamil Eelam (LTTE).⁴ Today, Sri Lanka exists within a conflicting paradigm: A Sinhalese state premised on principles of federalism on the one hand, and an LTTE-envisioned bipartite entity on the other. Historical and political factors influence responses of the state on many levels, and impact access to information pertaining to the north-east of Sri Lanka.

1. DRUG USE AND HIV/AIDS: RISKS AND VULNERABILITIES

1.1 Drug Use

Historically, most drug use was reported to be for medicinal purposes. Frequently used drugs

included cannabis (ganja), opium and alcohol;⁵ cannabis and opium also had medicinal use.⁶ Heroin is believed to have entered Sri Lanka in the early 1980s.⁷ Opium consumption is believed to have reduced after the "opium boutiques" were shut down⁸

Currently, drug consumption is considered to be high and inhalation is the popular mode of intake. The most commonly used drugs are alcohol, cannabis and heroin.⁹ There are an estimated 300,000 drug dependents, of which 40,000 are heroin dependent users¹⁰ and 2,00,000 are cannabis users¹¹. Most users are reported to be youth;¹² below the age of 19. The majority of drug users belong to the lower socio-economic bracket and many reportedly expend up to Rs. 50 per day on illicit drugs.

Evidence shows that in the northeast of Sri Lanka, the presence of brown sugar is increasing in the coastal belt amongst fishermen, correlating with a similar increase in India.¹³ Additionally, the drug MDMA, commonly known as the rave-drug "ecstasy", is reportedly gaining popularity.¹⁴

1 Known as Ceylon until 1972.
2 2003 estimate from <http://www.youandaids.org/Asia%20Pacific%20at%20a%20Glance/SriLanka/index.asp#response>.
3 Ibid.
4 See "Background Note: Sri Lanka", at <http://www.state.gov/r/pa/ei/bgn/5249.htm>.

5 Id. Drug Demand Reduction Report (DDRR), available at <http://www.wesouthasians.org/html/modules/home/south1998/ddch4.pdf>
6 "Revisiting the Hidden Epidemic" at <http://www.chr.asn.au/freestyler/gui/files/SriLanka.pdf>
7 Police Narcotics Bureau, Sri Lanka, Annual Report 2003.(On file with authors)
8 Ibid. See also DDRR above n5.
9 [Data obtained through persons in treatment. No Rapid Assessment Surveys available.
10 See "Youth Drug Abuse—The Silent Epidemic" Daily News (21 August 2001).
11 DDRR above n5.
12 Ibid.
13 Interview with Police Narcotics Bureau (October 2004).
14 MDMA is 3-4 methylenedioxyamphetamines, See Also PNB Annual Report above n7.

The use of prescription drugs for purposes of intoxication is also growing. Prescription of illicit drugs by 'quacks' is reported to be a matter of concern.¹⁵

It is reported that 40–50% of the population in prisons is incarcerated for drug offences.¹⁶ Approximately 24% of heroin users in Sri Lanka are within the prison system.¹⁷

1.2. Injecting Drug Use

Of 30,000 estimated drug users (DUs), 2%, or 600 persons, are injecting drug users (IDU).¹⁸ A behavioral study with beach boys and tourists showed that 1–2% of them had tried to inject drugs.¹⁹ Injecting drug use does not appear to be a serious problem in Sri Lanka.²⁰

The extent of HIV prevention among IDUs is not known. Till date, only one HIV positive person has admitted to injecting and the National STD/AIDS Control Programme is in the process of following up with questions.²¹ Aside from this, no data exists to show a correlation between HIV and injecting drug use in Sri Lanka, and tourists, the group believed to be injecting, are known to be taking drugs orally.²²

According to one source, the rates of AIDS deaths in the IDU community are very low.²³ This information

is supported by the Police Narcotics Bureau (PNB), which reports not seeing any increase in injecting drug use in their investigations. At the same time, some apprehend that like in India, in 1 or 2 years, IDU rates will witness an increase in Sri Lanka.

1.3 Other Vulnerabilities

(a) Sex workers

Reportedly, there are 30,000 women/girls and 15,000 boys engaged in sex work in Sri Lanka.²⁴ There are no reported red light districts in the nation's capital, Colombo.²⁵ Rather, sex workers are visible in alleys of main roads in Colombo.²⁶ 97% of sex workers in Colombo finished grade 7–8, at the very least.²⁷

High percentages of sex workers and their clients have STDs.²⁸ HIV seroprevalence remains low; out of sex workers tested in Colombo between 1990–1998, only 0.2% tested positive for HIV/AIDS at one site.²⁹ Additionally, HIV was detected at only one such site outside of Colombo, with 0.5% of sex workers at that site testing positive for HIV.³⁰

Drug use is also reported among sex workers, particularly those below the age of 35 years.³¹ Consumption becomes a regular practice within months of entering sex work.³² Some women reportedly sell sex to support the drug use habits of their partners.³³ At one NGO interviewed, at least two women clients were injecting drug users.³⁴

15 Feedback on overview and findings of the review from Kammalini D'Silva, Secretary, Ministry of Social Justice, Govt of Sri Lanka at the Regional Tripartite Review Meeting, Colombo, Sri Lanka, 30–31 March 2006

16 www.chr.asn.au

17 DDRR above n5.

18 World Bank Report (2002), available at <http://lnweb18.worldbank.org/sar/sa.nsf/8b211d2239d56913852567d7005d8e54/7db037e81492cb4585256a9b0054699d?OpenDocument> There is another estimate of 40,000 heroin users in Sri Lanka. Also note there is a prevalent belief that Sri Lankans are afraid of injections of any kind, see Interviews.

19 Ibid. This study was nine years ago.

20 Ibid.

21 Interview with Dr. Kulasiri from the National HIV/AIDS Control Programme (October 2004)

22 Ibid.

23 Interview with Dr. Jayawardena, former WHO/UNAIDS focal point, who cited autopsies as indirect evidence of this. (October 2004).

24 World Bank Report above n17.

25 Interview with Dr. Jayawardena above n22.

26 Ibid.

27 Ibid.

28 Ibid.

29 Sri Lanka HIV/AIDS Information, available at <http://www.youandaids.org/Asia%20Pacific%20at%20a%20Glance/SriLanka/index.asp#response>

30 Ibid.

31 Interview with Sunila Abeyasekara, Director of INFORM. (October 2004)

32 Ibid.

33 Interview with Dr. Kulasiri above n20. It is very rare to find women addicted to alcohol and cigarettes. The pressures of sex work push people to use drugs because the high makes them forget.

34 Ibid.

Members from a collective of sex workers³⁵ in Paldiagoda, outside Colombo, reported that most drug users are inhalers. Most of the interviewees stated that drug use is a habit that they picked up during sex work, not that they entered sex work to support a drug habit.³⁶ Members of the collective reported that injecting does take place, albeit rarely.³⁷

(b) Migrants

The conflict situation and the ensuing violence has resulted in extensive migration; internally from affected areas to other parts of Sri Lanka, as well as from Sri Lanka to Tamil Nadu, India. There is also significant migration to the Middle East for domestic work, primarily by women.³⁸ Such migration enhances vulnerability to exploitation and sexual abuse. Furthermore, due to the recent tsunami that wrought havoc on the island, excessive displacement has taken place. Such massive displacement is often linked with gender-based violence, increased drug use, and the spread of the HIV infection.

(c) Prisoners

There are approximately 25,000 inmates in Sri Lankan prisons.³⁹ Nearly 10,000 persons were convicted in 2003 alone for drug-related offences.⁴⁰ It is also reported that many of the offenders have been jailed for their inability to pay fines.⁴¹

There are a number of offenders who have been arrested for possessing a very small amount of prohibited drugs.⁴² Inability to pay fines results in a prison sentence.⁴³ It is also reported that magistrates, when handing out an order to remand, in the absence of the payment of a fine, sentence them.⁴⁴ Such a sentence is irreversible and mandatory.⁴⁵ When the sentence is in addition to the payment of a fine, and if the convict is unable to pay the same, the prison term gets enhanced.⁴⁶

Drug use is rampant in prisons.⁴⁷ Non-users are often initiated into drug use within custodial settings. Use of crack and cocaine, along with heroin, is reportedly on the rise.⁴⁸ Inhaling is the predominant mode of drug use and injecting is considered to be insignificant, though anecdotal data suggests that it is on the rise in jails.⁴⁹ Officials express concern over alleged prison killings by drug barons.⁵⁰ Coercive sex is also reported and alarmed prison authorities are asking for HIV education materials for inmates.⁵¹

1.4 HIV/AIDS

The first case of HIV was reported in Sri Lanka in 1987. The prevalence of HIV in Sri Lanka is reported to be relatively low, with less than 0.1% of the total population infected. In 2003, there were 3,500 reported cases of HIV in Sri Lanka.⁵²

35 The Collective is called Praja Shakthi Sangwardana Padanama (Sinhala), which, in English means Community Strength/Development Foundation.

36 Interview with Praja Shakthi Sangwardana Padanama (Sinhala) (October 2004).

37 Interim report, DU/SW Project, June 2003-Sept 2004, NDDCCB funded. Members of the collective reported that they have met 2-3 sex workers who claim they were injected by someone else who injects.

38 Sri Lanka HIV/AIDS Information above n28.

39 "Sri Lanka tackles jail crime" (30 July 2003), available at www.bbc.com.

40 "Ministry conceives coast guards" Jayampathy Jayasinghe (4 July 2004). However, an interview with Commissioner General of Prisons, Romy Marzook, notes that there are 19,000 prisoners in September 2003.

41 "Reforming the Prison System" Daily News Sri Lanka (4 August 2003).

42 "Free a Prisoner and Gain Merit" Jayanthi Liyanage (7 September 2003).

43 "Reforming the Prison System" above n40.

44 "Free a Prisoner and Gain Merit" above n41.

45 Ibid.

46 Ibid.

47 Interview with PNB above n13.

48 Interview with Dr.Kulasiri above n20.

49 Interview with PNB and Dr. Kulasiri ibid.

50 Feedback on overview and findings of the review from Kammalini D'Silva, Secretary, Ministry of Social Justice, Govt of Sri Lanka at the Regional Tripartite Review Meeting, Colombo, Sri Lanka, 30-31 March 2006

51 Interview with Dr.Kulasiri ibid.

52 UNAIDS/WHO "Report on the Global AIDS Epidemic" (2004), available at <http://www.unaids.org/en/geographical+area/by+country/sri+lanka.asp>. Note also that the stigmatized nature of the disease in Sri Lanka shows that Sri Lankans go so far as to travel abroad for treatment, to preserve anonymity. See Interview with Dr.Jayawardena above n22.

Approximately 98% of blood and blood products are presently screened for HIV.

2. DRUG USE AND HIV/AIDS LAW AND POLICY FRAMEWORK

2.1 Overview of the Legal Framework

2.1.1 Constitution

Frequent changes in political leadership in the latter half of the 20th century led to the creation of different versions of the Sri Lankan Constitution. The Constitution adopted in 1972 changed the name of the country from Ceylon to Sri Lanka, introduced the office of the President, and proclaimed commitment to the protection of Buddhism.⁵³ In 1978, a new Constitution came into effect, shifting from a Westminster model of governance to a French form⁵⁴ where the President and not the Prime Minister is the most powerful office-holder within the parliamentary system.⁵⁵

Under the Constitution, the authority of the Sri Lankan government is vested in the President, Prime Minister, Parliament and the judiciary.⁵⁶ The President of the republic is elected for a six-year term and works with the Prime Minister and Parliament to fulfill their respective duties under the Constitution.⁵⁷ Although the President and Prime Minister have traditionally hailed from the same party, since 2001 this has not been the case.⁵⁸ This divergence has resulted in severe tensions within government.⁵⁹ Furthermore, the Sri Lankan government has granted authority to local provinces to participate in decision-making with, or under the scrutiny of, the central government.⁶⁰

The Constitution guarantees and protects Fundamental Rights, contained in Chapter III, including the right to equality and the equal protection of the laws for all persons.⁶¹ It also prohibits discrimination against citizens on specific grounds, including "race, religion, language, caste, sex, political opinion, place of birth or any such grounds."⁶² Furthermore, it permits special provisions to be made for women, children and disabled persons.⁶³ It protects many freedoms, including freedom of speech, assembly, association and movement subject to reasonable restrictions.⁶⁴ It ensures protection against arbitrary arrest, detention and punishment and prohibits retroactive application of penal statutes.⁶⁵

2.1.2 Courts⁶⁶

Sri Lanka's legal system reflects diverse historical influences: criminal law stems from the British, the civil law regime is Roman-Dutch and laws pertaining to marriage/divorce/inheritance are communal/personal.

The Judicature Act, 1978, provides for the structure of judicial administration.⁶⁷

The judiciary comprises the Supreme Court, Court of Appeal, High Court, civil and criminal Courts, and a number of subordinate Courts. The Magistrate's Court is the Court of first instance hearing criminal cases.⁶⁸ The High Court hears criminal matters in exceptional cases, and the Court of Appeal and Supreme Court have appellate jurisdiction over criminal cases.⁶⁹ The Supreme Court also has jurisdiction over cases pertaining to the violation of fundamental rights.⁷⁰

53 The commitment to Buddhism is set out in Article 9.

54 Background Note: Sri Lanka above n4.

55 Countrywatch "Sri Lanka: Government Functions", at <http://www.countrywatch.com>.

56 Constitution Chapter I Section 4, Chapter VII-XII.

57 Background Note above n4. The Prime Minister heads the ruling party in Parliament. Parliament itself is comprised of 225 elected members and is vested with the power to make laws.

58 Ibid.

59 Ibid.

60 Under the Indo-Sri Lankan Accord of July 1987, and the resulting 13th amendment to the Constitution.

61 Article 12(1), Sri Lanka Constitution.

62 Article 12(2). Though the 1978 Constitution recognizes other religions, the principal religion of Sri Lanka is Buddhism. See Article 9, article 13, and Chapter II.

63 Article 12(4).

64 Article 14.

65 Article 13.

66 Background Note, above n4.

67 Ibid.

68 Lectric Law Library "Criminal Justice System of Sri Lanka" at <http://www.lectlaw.com/files/int20.htm>

69 Ibid.

70 Ibid.

2.1.3 Criminal justice system

The Penal Code of 1833 provides for criminal offences, punishments and exceptions to criminal culpability.⁷¹ Sri Lankan criminal procedure is enshrined in the Code of Criminal Procedure Act (1979).

2.2 Drug Use and HIV/AIDS Harm Reduction Law

2.2.1 General penal provisions

There are provisions of the penal code that provide for culpability on account of abetment, common intention and criminal conspiracy. These provisions are relevant for harm reduction programs, e.g. if an NGO started drug substitution therapy/NSEP.⁷²

Certain provisions of the Penal Code may obstruct the proliferation of drug substitution therapy centres.⁷³ For example, "causing any person to take specific types of drugs with an intent to commit or facilitate the commission of an offence" is punishable by imprisonment of up to ten years and a fine. Additionally, the Code criminalizes "whoever administers to, or causes to be taken by any person any poison or any stupefying, intoxicating or unwholesome drug or other thing, with an intent to cause hurt to such person, or with intent to commit or facilitate the commission of an offence or knowing it to be likely that he will thereby cause hurt".⁷⁴

2.2.2 Sex work⁷⁵

The Penal Code proscribes the procuring, removing or detaining a person for purposes of prostitution.⁷⁶ Such an offence is punishable with

a fine and with imprisonment for 2 to 10 years.⁷⁷ It also prohibits procuring a person for purposes of employment within a brothel and detaining a person without their consent for purposes of sexual intercourse or abuse.⁷⁸ The punishment for procuring persons under the age of 16 for illicit sexual intercourse enhances the penalty to 5-20 years imprisonment.⁷⁹ A 1998 amendment to the Penal Code further criminalizes hiring, employing, persuading, inducing or coercing a child to procure any person for illicit sexual intercourse,⁸⁰ punishable with imprisonment for 2 to 5 years.

2.2.3 Drug use

There are two laws that govern the use of drugs in Sri Lanka: (1) The Cosmetics, Devices and Drugs Act (CDDA) deals with pharmaceutical drugs and was enacted to regulate and control the manufacture, importation, sale and distribution of cosmetics, devices and medicinal drugs;⁸¹ and (2) the Poisons, Opium and Dangerous Drugs Act (PODD) directly deals with the trafficking and use of narcotics and psychotropic substances.

The CDDA requires a person who is engaged in the manufacture, import, preparation, store or sale in drugs, cosmetics and devices to acquire a license from the Cosmetics, Devices and Drugs Authority, thus enabling the monitoring agencies to regulate and keep watch on import, production, sale and distribution of drugs, cosmetics and devices.⁸²

71 Lectric Law Library above n66.

72 Interview with Yasantha Kodagoda, Attorney General's Office (October 2004)

73 Ibid.

74 Section 319.

75 See http://www.protectionproject.org/human_rights/countryreport/sri_lanka.htm. For example, the Penal Code prohibits anyone from procuring a person with the intent that the person becomes a prostitute.

76 Ibid.

77 Ibid.

78 Ibid.

79 Ibid.

80 Ibid.

81 Preamble, The Cosmetics, Devices and Drugs Act, 1980 (CDDA)

82 CDDA. There are provisions of the Act that in theory can be used against NSEP, to criminalize such activity in the context of hypodermic syringes. According to the Attorney General's office, these provisions would not be used in the context of NSEP and drug substitution therapy, because the PODD, not the CDDA, applies in the context of narcotics. It is implied that the Attorney General's office does not classify drug substitution therapy as medical treatment, and devices such as needles would not fall under the CDDA because offences relating to narcotics do not fall within the purview of this Act.

The PODD was passed on 4 July 1929.⁸³ However, sensing difficulties in implementing the Act, the authorities postponed its implementation.⁸⁴ After an amendment in 1935, the Act came into operation on 1 January 1936.⁸⁵ Since then, the PODD has undergone significant changes.⁸⁶ The amendments of 1982, 1984 and 1986 introduced major changes in the Act, and its effectiveness enhanced.⁸⁷

(a) *Classification of prohibited substances*

The third schedule to the PODD sets out the prohibited substances and related offences as follows:

- (a) Group A refers to any product obtained from any of the phenanthrene alkaloids of opium or from the ecgonine alkaloids of the coca leaf subject to restrictions.
- (b) Group B includes medicinal opium, hemp, morphine, cocaine and others. The amended schedule specifically includes methadone, amongst others.
- (c) Group C includes codeine, pethidine and others.

Although methadone is expressly prohibited, buprenorphine does not receive specific mention in the Schedule.

For the drugs in Group B, the provisions of the PODD related to importation, exportation and wholesale and retail trade apply. For methadone, which is included in this category, the following provisions would apply: sections 48 (dangerous drugs), 51 (wholesale and retail trade subject to regulations) and 68 (restriction, control or supervision of wholesale drug).⁸⁸

83 Jayasuriya, Penal measures for drug offences: perspectives from some Asian countries, (1984) http://www.unodc.org/unodc/bulletin/bulletin_1984-01-01_3_page004.html#s010

84 Ibid.

85 Ibid.

86 Ibid.

87 Ibid.

88 Asian Harm Reduction Network, www.ahrn.net.

However, the use of methadone as a treatment drug for detoxification was not known till recently.⁸⁹

(b) *Offences and penalties*

The PODD criminalizes a variety of activities related to dangerous drugs. Read together or separately, the provisions may serve as an obstacle to harm reduction programs in Sri Lanka.⁹⁰

The possession of dangerous drugs without a license is expressly prohibited.⁹¹ The PODD also criminalizes knowingly consuming dangerous drugs without a prescription from a medical practitioner.⁹² The implication of this section is that possession and consumption are permissible if a license or prescription is procured.

Manufacturing, trafficking (selling, giving, procuring, storing, administering, transporting, sending, delivering or distributing), possessing, importing or exporting of specified dangerous drugs is proscribed under Section 54-A.⁹³

Collection, preparation, process, sale or offer for sale, manufacture, storage, obtaining, possession, consumption, distribution or usage of exudate of poppy plant such as opium, morphine, heroin or preparation thereof is prohibited.⁹⁴

Criminal culpability arises for a person who abets the commission of an offence under section 54A, or does any act preparatory to, or in furtherance of, the commission of an offence mentioned under section 54A.⁹⁵ As a rule, bail is denied to persons

89 See *ibid.*

90 Sections 52 to 54.

91 Section 52.

92 Section 52.

93 Specific dangerous drugs are heroin, cocaine, morphine or opium. The 1984 amendment to the PODD introduced sections 54A and 54B, prescribing penalties for drug offences. Section 54A. See Chart I on the following page, "Prohibited Substances and Penalties", for the type and quantity of dangerous drugs, and the nature of punishment.

94 Section 29.

95 Section 54B.

held under these sections except in special circumstances, as directed by the High Court.⁹⁶

Manufacture of heroin, cocaine, morphine or opium is punishable by death or life imprisonment.⁹⁷ Trafficking (selling, giving, procuring, storing, administering, transporting, sending, delivering or distributing), possessing, importing or exporting of dangerous drugs (heroin, cocaine, morphine, opium and cannabis) in excess of specified quantities is punishable with sentences ranging from three years to life imprisonment or death.

(c) Treatment and rehabilitation

The PODD allows a medical practitioner to "administer, prescribe or supply any dangerous drug" to a patient for purposes of treatment, provided the stock does not exceed a period of three days.⁹⁸ Furthermore, it also allows any person to "administer any dangerous drug in accordance with the order of medical practitioner, veterinary surgeon or dentist." Lastly, a pharmacist may on premises licensed for the purpose by the Director, supply a dangerous drug on prescription of medical practitioner, dentist or veterinary surgeon.⁹⁹ Read together, these sections appear to permit medical practitioners and pharmacists to prescribe or administer drug substitutes. However, no person shall sell, supply, and deliver any poison to a person less than twelve years of age except on the prescription of the medical practitioner prescribing the poison for the use of that person.¹⁰⁰

A dangerous drug has to be prescribed by a medical practitioner, dentist or veterinary in writing and with specific details.¹⁰¹ This provision implies that prescription of oral drug substitutes to heroin dependent users may be permissible under the

PODD. The protocol for prescription of dangerous drugs is elaborated upon in the PODD.¹⁰²

The PODD allows only medical practitioners, dentists, veterinary surgeons, pharmacists or wholesale druggists to make, import or possess a hypodermic syringe.¹⁰³ It expressly prohibits possession of injection paraphernalia except on the orders from the medical practitioner. Therefore, persons using hypodermic syringes in contravention of this section are liable to be punished under the law, leaving open the possibility that needle exchange programs can be held liable for abetment.¹⁰⁴

There are no express provisions under the PODD to enable Courts to divert offenders with substance dependence to treatment and rehabilitation. According to government officials, first time users are taken into community correction programmes and not sentenced.¹⁰⁵ In the absence of legislative provisions, detoxification and rehabilitation appears to be guided by policy initiatives of the NDDCB.

(d) Statutory structure for implementation

The National Narcotics Advisory Board was established in 1973 to serve as an advisory body on drug control.¹⁰⁶ As drug use increased, the government initiated a process to formulate a comprehensive national policy.¹⁰⁷ The National Dangerous Drugs Control Board Act was brought into operation in 1984, and the National Dangerous Drugs Control Board (NDDCB) was established under the Ministry of Defence.¹⁰⁸ It is the primary entity today dealing with drug control in Sri Lanka.¹⁰⁹ It engages in various activities for prevention and

96 Section 83, sections 54A and B.

97 Section 54A.

98 Section 56.

99 Section 57.

100 Section 13.

101 It must be dated and signed, with the person's name and address for whom it has been prescribed, and the total amount of drug to be supplied (shall not be more than three days dosage).

102 Section 59.

103 Section 65.

104 Section 65.

105 Feedback on overview and findings of the review from Kammalini D'Silva, Secretary, Ministry of Social Justice, Govt of Sri Lanka at the Regional Tripartite Review Meeting, Colombo, Sri Lanka, 30-31 March 2006

106 DRR above n5 at 106.

107 Ibid.

108 Ibid.

109 Ibid.

treatment.¹¹⁰ The NDDCB includes members with diverse expertise, including education, health, police, customs, government and Ayurveda.¹¹¹ The head is politically appointed.¹¹² Importantly, the involvement of NGOs is reportedly encouraged, and the Sri Lanka Federation of NGOs Against Drug Abuse (SLFONGOADA) was formed in 1986.¹¹³

The Police Narcotic Bureau (PNB) was set up on 1 April 1973 and is the primary agency for containment of drug use in Sri Lanka.¹¹⁴ A unit of the PNB was set up at Bandaranayake International Airport in 1989, after Interpol identified Sri Lanka as a transit country in international drug trafficking.¹¹⁵ Under the PODD, the PNB may investigate drug offences in any part of the country with the permission of the Inspector General of Police.¹¹⁶ The functions of the PNB include prevention, detection, prosecution and the collection of evidence in drug related cases.¹¹⁷

In 2003, narcotics offences resulted in 21,170 Magistrate Court and 515 High Court cases.¹¹⁸ A typical High Court case takes 3-5 years to be tried and decided.¹¹⁹

(e) Law reform efforts

Nearly a decade ago, a process was initiated to reform the PODD, to create a realistic and viable response to illicit drug use in Sri Lanka.¹²⁰ Unfortunately, the draft never reached Parliament, due to several policy changes.¹²¹ The PODD thus stands in its original form today, despite recognition that the law is unnecessarily, ineffectively harsh on

drug users. During the period when reform of PODD was attempted, there was a belief that anti-money laundering legislation was required simultaneously.¹²² However, this effort was halted due to concerns of the banking and financial institutions.¹²³

Since the last amendment came into force, the drug scenario in Sri Lanka has changed significantly.¹²⁴ Drug consumption patterns have shifted, youth are experimenting with newer drugs and the illicit use of pharmaceutical drugs is growing.¹²⁵ When the draft PODD was originally developed, the overall legal approach to dealing with narcotics and psychotropic substances was that of "zero tolerance",¹²⁶ which is attributed to the gravity of the drug problem and political turmoil, as well as popular scientific thinking of the time.¹²⁷

The NDDCB drafted a new comprehensive legislation to replace the PODD Act, by the Legal Draftsman LD 56/95, which is now with the Attorney General. The Drug Control Board Annual Report (2003) states that the proposed legislation would incorporate the articles of the 1988 Convention and SAARC Convention.¹²⁸ The proposed legislation also includes the thus far ignored but crucial aspect of treatment and rehabilitation for drug users.¹²⁹ The draft legislation is still considered to be "in the works", with a catalyzing force required to restart the process.¹³⁰ Support for the legislation appears to be strong within government.¹³¹

110 Ibid.

111 Ibid at 105.

112 Interview with Dr. Jayawardena above n22.

113 DRRR above n5 at 106. For further discussion on SLFONGOADA's work, see Section 3.2.1, *infra*.

114 Police Report on Narcotics, www.police.lk/divisions/narcotics.html.

115 Ibid.

116 Ibid.

117 Ibid.

118 PNB Annual Report above n13.

119 Ibid.

120 Interview with Mr. Kodagoda above n70.

121 Ibid.

122 Ibid.

123 Interview with Mr. Kodagoda above n70.

124 The Drug Control Board Annual Report (2003) and Interview with Mr. Kodagoda *ibid*.

125 Ibid.

126 Interview with Mr. Kodagoda above n70.

127 Ibid.

128 The Drug Control Board Annual Report above n121 and Interview with Mr. Kodagoda above n70.

129 Interview with Mr. Kodagoda above n70.

130 Ibid.

131 In the context of possession as a punishable offence, the Attorney General's office supports increasing the requisite number of grams from one to ten. The Attorney General office's reasons are practical: the harsh penalty for possession of [one] gram mandates the AG to demand trial, and meeting the "beyond reasonable doubt" standard of proof is extraordinarily difficult in such circumstances. The office of the AG prefers a standard of 10 grams. The PNB also supports the draft law, since drug users are predominantly arrested and traffickers are rarely charged.

2.3 Policy Framework for Drug Abuse and HIV/AIDS

2.3.1 Drug demand reduction

The National Master Plan, Sri Lanka (1993) sets out the action plan to implement National Policy for the Prevention and Control of Drug Abuse. Four phases are articulated for implementation of the policy, namely - (1) linking problems and needs, (2) securing broad political commitment, (3) strengthening administrative machinery, and (4) carrying out selected demand machinery.¹³²

The policy seeks to address the illicit drug problem using a four-pronged strategy, encompassing (1) enforcement; (2) preventive education and public awareness; (3) treatment, rehabilitation and aftercare; and (4) international and regional cooperation.

A draft "National Policy for the Prevention and Control of Drug Abuse" is currently waiting approval.¹³³ This draft acknowledges Sri Lanka's obligations under the International Conventions on Narcotics, and prescribes stringent procedures for the realization of these obligations.¹³⁴ More specifically, the draft sets out a revised four-pronged strategy, consisting of (1) effective monitoring of imports, exports, distribution of drugs and precursor chemicals under control; (2) effective enforcement of law against production, smuggling, trafficking, sale and use of illicit drugs; (3) preventing the use of drugs and reducing the adverse consequences of drug abuse; and (4) supporting regional and international initiatives.¹³⁵

Recognizing links between drug use and HIV/other sexually transmitted infections (STIs), the draft policy states that treatment programs will perform

testing for these infections, raising the question of whether such testing will be mandatory for drug users in treatment programs.¹³⁶ The draft further states that treatment programs will "provide counselling to help patients modify or change behaviors that place themselves or others at risk of infection."¹³⁷

2.3.2 HIV/AIDS

In 1992, Sri Lanka's National STD Control Program began implementing the HIV prevention and control program.¹³⁸ This program, subsequently renamed the National STD/AIDS Control Programme (NSACP), is under the administrative control of the Ministry of Health and conducts targeted interventions, condom promotion and availability, improvement of STD programs, and conducting STD/AIDS education programs for the youth.¹³⁹ It focuses on HIV/AIDS prevention and care/treatment, including for injecting drug users. Furthermore, it proposes to reach STD patients and sex workers, drug users among other persons engaging in high-risk activity.

The National AIDS policy of the Government of Sri Lanka is designed to prevent the spread of HIV and reduce the burden of HIV/AIDS on infected persons, as well as on the health and socio-economic status of the Sri Lankan people. The document recognizes that vulnerability is exacerbated by economic, cultural, and biological factors such as poverty, stigma and discrimination, lack of access to information and healthcare. In response to such factors, the policy sets out strategies that prevent the spread of HIV/AIDS, while simultaneously ensuring the

132 DDRR above n5 at 106-7.

133 Draft Policy

134 Ibid.

135 Draft Policy.

136 Ibid.

137 Draft policy on prevention and control of drug abuse, submitted for approval 2004.

138 <http://lnweb18.worldbank.org/sar/sa.nsf/8b211d2239d56913852567d7005d8e54/7db037e81492cb4585256a9b0054699d?OpenDocument>.

139 Epidemiological fact sheet, available at undp.org.in/contryfsheet/srilanka.htm, See also World Bank Report, available at <http://lnweb18.worldbank.org/sar/sa.nsf/8b211d2239d56913852567d7005d8e54/7db037e81492cb4585256a9b0054699d?OpenDocument>.

realization of human rights for all, including persons living with HIV/AIDS.

The second stated goal of the policy is to reduce transmission of HIV through infected blood, including through intravenous drug use and the sharing of contaminated needles. However, the strategy proposed to achieve this goal focuses on prevention and elimination of intravenous drug use, and does not mention harm reduction measures such as NSEP or drug substitution therapy. This absence of harm reduction strategy is possibly due to the relatively low prevalence of HIV and injecting drug use in Sri Lanka.

3. DRUG USE AND HIV/AIDS HARM REDUCTION PRACTICES

3.1 Prevention

3.1.1 Drug use

A UNODC report suggests that high literacy/education in the country can be asset for drug prevention programmes.¹⁴⁰ Another report notes that school prevention programmes have not had much impact. This is evident from the fact that drug dependence is predominantly seen among the youth i.e. persons between 20–35 years.¹⁴¹ No other information was found on the internet.

3.1.2 HIV/AIDS

(a) *Information Education Communication (IEC)/Behavior Change Communication*

HIV awareness and knowledge levels in underserved communities remain drastically low. Only 40% of women working in rural tea estates, for example, have even heard of HIV/

AIDS, as compared with 90% of women in other rural and urban areas.¹⁴² Under the NSACP, the government has instituted a communication programme using mass media to increase information and awareness of HIV. Recognizing that an open and candid discussion on sex and sexuality is unavoidable in effectively informing the public about risks and protection against HIV, the government has announced eased restrictions on the use of "scientific or medical" terms for describing sex or sexual organs.¹⁴³

(b) *Condom promotion*¹⁴⁴

The Government supports HIV/AIDS prevention interventions that encourage condom usage, as do family planning programs.

Anecdotal information suggests that attempts made to make condoms available in prisons failed.¹⁴⁵ Condom distribution in prisons was mooted a second time in the recent past but is reportedly being opposed by the Health Ministry on the grounds that it will send the wrong message.¹⁴⁶ The Ministry cites the Penal Code proscription against sodomy as the reason and HIV is not factored into such decision-making.¹⁴⁷

(c) *Treatment for Sexually Transmitted Diseases (STDs)*

STD and HIV rates are correlated in the country, and programming is designed accordingly.¹⁴⁸

140 http://www.unodc.org/pdf/india/publications/south_Asia_Regional_Profile_Sept_2005/13_srilanka.pdf#search=%22PREVENTION%20OF%20DRUG%20USE%20IN%20sri%20lanka%22

141 <http://www.chr.asn.au/freestyler/gui/files//SriLanka.pdf#search=%22Programs%20for%20Drug%20abuse%20prevention%20in%20Sri%20Lanka%22>

142 <http://web.worldbank.org/WBSITE/EXTERNAL/COUNTRIES/SOUTHASIAEXT/EXTSAREGTOPHEANUT/EXTSAREGTOPHIVAIDS/0,,contentMDK:20287586 menuPK:568884 pagePK:34004173 piPK:34003707 theSitePK:496967,00.html>

143 Source: Background document for the discussion with stakeholders for the development of the National AIDS Policy, DATED 10/1/2005.

144 It has been reported that when condom distribution is attempted, there is public outcry that they are attempting to curb the growth of the Sinhalese population. This aspect of the cultural context is an issue raised in risk reduction programming. See interview with PNB.

145 Interview with Dr. Jayawardena above n22.

146 Interview with Sunila Abeysekera above n30.

147 Ibid.

148 Interview with Dr. Kulasiri above n20.

(d) VCT

The government provides counselling for HIV-positive persons.¹⁴⁹

(e) Needle Syringe Exchange Programme (NSEP)

There are no reported NSEPs at this time in Sri Lanka. However, this information does not apply to the North or East of Sri Lanka, for which data was not available.

(f) Oral drug substitution programs

Presently, there are no formal drug maintenance programs operating in Sri Lanka. However, anecdotal information suggests that psychiatrists are prescribing and providing methadone.¹⁵⁰ General practitioners too are reportedly offering methadone to drug users, along with counselling.¹⁵¹ No further information was available, making it difficult to ascertain the nature and manner of methadone prescription.

The lack of NSEP/drug substitution therapy programs can be attributed to the relatively low prevalence of injecting drug use and HIV in Sri Lanka, and a belief that such programs are contextually inappropriate. Most persons interviewed thought that the idea of NSEP or drug substitution therapy in Sri Lanka is premature; not only is injection drug use believed to be non-existent, it is also considered unlikely to emerge as a concern in the near future.¹⁵² If and when harm reduction is introduced, there is likely to be a strong demand for checks and balances, what with fears of misuse and corruption abound.¹⁵³

Harm reduction is a novel programmatic strategy for both health interventionists and law

enforcement officers in Sri Lanka. However, the Attorney General's (AG) office has not rejected the idea conceptually and is willing to examine HIV and IDU harm reduction as and when the need arises.¹⁵⁴ According to a senior official at the AG's office, it is imperative to examine similar environments where harm reduction programs have been effective.¹⁵⁵ Specifically, Sri Lankan officials are skeptical of NSEP and drug substitution therapy analyses as carried out in the West.¹⁵⁶ Officials expressed the need to see an "importable" context, i.e. similar programs carried out "closer home" in the SAARC region, with an analysis of practicalities and pitfalls including potential legislative changes to accommodate such measures.¹⁵⁷

3.2 Treatment

3.2.1 Drug treatment and rehabilitation

The NDDCB along with some NGOs undertakes treatment and rehabilitation of drug users.¹⁵⁸ Until the late 1980s, treatment modalities were medically intensive, rehabilitation and social re-integration of drug users was mostly ignored.¹⁵⁹ Subsequently, NGOs pushed for integrating treatment, counselling and rehabilitation within drug abuse programs.¹⁶⁰ Currently, SLFONGOADA and other NGOs along with the NDDCB conduct treatment and rehabilitation.¹⁶¹ The NDDCB runs treatment and rehabilitation centres in three major cities in Sri Lanka—four government centres with a total capacity of 143 beds and seven counselling and rehabilitation centres with 30 beds have been established.¹⁶² An NGO, Mithuru Mithuro Movement, runs nine rehabilitation centres, and other NGOs have set up three rehabilitation centres.¹⁶³

149 Ibid.

150 See Interview with Dr. Kulasiri above n20.

151 See Interview with Dr. Kulasiri above n20 and with Dr. Jayawardena above n22.

152 See Interview with Sunila, PNB, others (October 2004).

153 Ibid.

154 Ibid.

155 Ibid.

156 Interview with Mr. Kodagoda above n70 and PNB above n13.

157 Ibid.

158 See DRRR above n4 at 106.

159 Ibid.

160 Ibid.

161 Ibid.

162 Ibid.

163 Ibid.

Sex workers dependent on drugs find it difficult to access treatment as most centres are closely linked with the government and cater only to male drug users.¹⁶⁴ The sex workers' collective keeps female drug users at a site outside Colombo, trying to get them to reduce drug use.¹⁶⁵ The sex workers' collective in Peliyagoda plans to have a camp for members who are dependent on drugs with support from the NDDCB, which has committed itself to providing implementation mechanisms.¹⁶⁶

Given the high number of drug users in prisons, drug treatment and rehabilitation efforts were intensified in prisons around 1999, after the introduction of the Community Based Corrections Act.¹⁶⁷ In 2002, the Boossa prison was converted into a rehabilitation camp where about 400 inmates can be accommodated.¹⁶⁸ Drug users have to spend two years in the camp to be considered fully rehabilitated.¹⁶⁹ Prisons remain a less than ideal setting for rehabilitation and relapse continues to be high.

164 See Interview with Praja Shakthi Sangwardana Padanama (Sinhala) (October 2004).

165 Ibid.

166 Ibid.

167 See Shanika Sriyananda "Kicking the Drug Habit from Behind Bars" Sunday Observer (20 June 2004).

168 Ibid.

169 Ibid.

IV. DISCUSSION

Countries of the SAARC region have much in common, amongst other things – common culture, history, geographical contiguity and very similar legal systems. Historically, as has been noted in the country chapters, drug use, particularly that of cannabis and opium, was culturally sanctioned in quite a few of the SAARC countries. Contemporary times beginning with the late 1970s and the early 1980s, have seen growing consumption and dependence on substances like heroin in most countries of the region, which is geographically wedged between the Golden Crescent in the west and the Golden Triangle in the east, areas that supply illicit drugs to the rest of the world. Throughout the 1990s, the switch from “chasing” to injecting was seen in four of the SAARC countries, namely Bangladesh, India, Nepal and Pakistan especially in urban sites. IDU and the attendant threat of blood borne infections like HIV/AIDS has emerged as a health crisis in all these countries with varying levels of intensity. Of the remaining three, Sri Lanka and Maldives report increasing incidence of substance abuse, albeit orally. Bhutan is witnessing a similar pattern of emerging drug dependence.

EXISTING LEGAL RESPONSE

The legal response to drug use, shaped by the three international drug conventions, has been underlined by a policy of prohibition to be executed through penal instruments. The legal framework rests on a system of proscriptions and penalties under the assumption that stringent penal sanction will deter drug-related activity including consumption. The international conventions specifically provide that states make

possession and personal consumption of drugs criminal offences. Following the conventions, drug laws all over the world, including in the SAARC countries, penalize possession and consumption.

The international drug conventions provide three avenues of treatment to drug dependent persons. Firstly, within the criminal justice system, the conventions mandate provisions that allow the drug user to opt for treatment in lieu of punishment; secondly, they mandate provisions that permit the drug user to consume drugs, otherwise prohibited, on medical prescription and thirdly, they mandate provisions outside the criminal process for the early detection, treatment, after care and rehabilitation of drug users. All these provisions find their place in some way or the other in the narcotics laws in SAARC countries in that they provide for treatment in lieu of conviction, or outside the criminal process, and permit access on prescription.

The concept of treatment, as understood in drug legislations including laws across the SAARC region, has been understood to mean detoxification and de-addiction of the drug user. Treatment provisions are contingent on the user “giving up” drugs completely.

As long as drug use did not affect the health of the other members of the public, it tended to remain a “law and order problem” for society or at best a “medical” problem for the addict. Public health considerations did not generally play a primary part in determining the approach to drug use.

ADVENT OF HIV/AIDS – A PARADIGM SHIFT

All this changed with the advent of HIV/AIDS, coinciding as it did, with the onset of injecting drug use. Injecting drug use is often risky and unsafe, especially if done with syringes that are unsterilized or shared between users. Once HIV enters a pool of injectors, many tend to get infected as a result of needle-sharing. Even if a small proportion of IDUs infected or at risk of HIV/AIDS, have unprotected sex, the implications for the health of other members of society become serious. Public health is now significantly and directly impacted by drug use.

In most SAARC countries it was realized that unless measures are taken to ensure that injecting drug users adopt safer behaviours, even while they continue with drugs, their own health as well as public health would be in jeopardy. It was in this context that harm reduction measures took root and gained significance.

In South Asia, the response to this reality came first from the field – when NSEP was started with a few IDUs in Lahore, Pakistan, and oral Buprenorphine was offered to opiate injectors in Nizammudin Basti in Delhi, and Methadone was prescribed at a small clinic in Kathmandu, Nepal. These were natural, organic and pragmatic responses based on what was happening in the field and not determined by political considerations.

These programs encouraged IDUs to visit drop in centres, attend health clinics and enroll in drug treatment and recovery programs. Protecting the rights of those most at risk of HIV/AIDS became an effective strategy to protect the rest of the public. It became clear that rights and the health of the individual drug user was directly and necessarily connected with the rights and health of the public.

As HIV prevalence widened among core and bridge populations in many countries in the region, governments felt the need for a formal programme

and policy response. Bangladesh, India, Nepal, Pakistan and Sri Lanka drafted official documents that, fortunately, acknowledged and to some extent endorsed the harm reduction model to public health. Though progressive and proactive in addressing the realities of HIV and IDU, policy directives on harm reduction have limited appeal as unlike laws, policies are not legally binding.

Drug control programs led by drug control authorities continue to be dominated by the detoxification and de-addiction models. As a result, there is a gap between the drug de-addiction and detoxification programs pursued by the national drug authorities, on the one hand, and harm reduction efforts led by HIV/AIDS control authorities, on the other. In some countries though, support for NSEPs, oral substitution, condoms and treatment in HIV/AIDS policies has been mirrored in drug policies. The positive articulation of harm reduction strategies in drug control plans of Nepal and Pakistan is one example. Similarly, the support offered by the Department of Narcotics Control to NSEPs in Bangladesh is another affirmative step. On a cautionary note, though, drug control authorities have started taking on board the lessons of the HIV/AIDS era, harm reduction programs are yet to be organically integrated into drug prevention and treatment programs in the region.

HARM REDUCTION – THE LEGAL ISSUES

The fundamental question that this review sought to answer is whether a public health approach that reduces drug related risks while acknowledging consumption is feasible within a legal regime of prohibition. Is harm reduction supported or hindered by national laws in the region? Can municipal laws, based on the international drug conventions, accommodate the response needed to contain the HIV pandemic? Or if they hinder such measures, whether there is any need to amend the laws and if so what is the nature of the amendments that is required?

This document does not prescribe what individual countries may or may not do in terms of modifying national laws. That is strictly the province of local stakeholders. All it does is indicate the broad typologies that could potentially be adopted. It is up to individual countries given their particular legal regimes and the interpretation of laws by judicial bodies, to make precise amendments if at all found necessary.

I. Include harm reduction within the rubric of medical treatment

All countries have similar legal provisions criminalizing possession, use and consumption of illicit drugs. This follows the rule laid down in international drug conventions. Additionally, in some countries, facilitation of, criminal conspiracy to commit and abetment of drug offences is proscribed under the anti-narcotics legislation. This is apart from crimes of aiding, instigating, abetting, criminal conspiracy and common intention set out in general criminal law as contained in country specific penal codes. It is under these ancillary crimes that harm reduction services, such as the provision of needle-syringe and condoms, could be legally obstructed unless an exception is carved out in law.

One typology of exceptions provided under international and domestic drug laws is 'medical use'. In other words, possession and consumption of drugs, which is otherwise outlawed, is permitted if prescribed for treatment or on account of medical necessity. The question that arises is whether harm reduction measures could be included within the rubric of treatment.

Treatment is an expansive term. According to the Concise Oxford Dictionary, treatment is "the process or manner of treating someone or something in a certain way", 'medical care for an illness or injury' Black's Law Dictionary defines treatment to mean "a broad term covering all the steps taken to effect a cure of an injury or disease, including examination, diagnosis as

was well as application of remedies". Treatment has also been understood to mean not only "an application of medical care to cure a disease but would also include a particular remedy, procedure or technique for curing or alleviating a disease, injury, or condition".

Thus, certain components of harm reduction including treatment and management of STDs, VCTs, treatment for HIV/AIDS, care and support, drug detoxification and possibly oral drug substitution could be read within the meaning of medical treatment for HIV/AIDS and/or drug dependence. Thus, countries could allow such programmes by expanding the scope of treatment in existing law. However, it remains to be seen whether preventive measures such as condoms and sterile needles, which reduce risk without necessarily remedying a medical condition could also be construed as medical treatment.

In one Indian case, it was held that issuing a prescription for spectacles by an eye specialist amounts to treatment. The Court held that the "word 'treatment' must be understood to be in fullest amplitude."¹ Treatment would then include steps not only to effect cure of some disease but also interventions that would prevent further deterioration of the condition. Accordingly, it was held that the expression treatment "connotes a remedial measure either to cure or to prevent deterioration". Arguably then, NSEPs may be covered in the expression treatment, especially if a medical authority prescribes or recommends sterile injection equipment to prevent attendant blood borne infections like HIV/AIDS.

However, it is important to remember that most countries in the region follow common law where the law is as it is read, interpreted and laid down by judges. Unless explicitly provided in the statute or rules framed there under, the judiciary may or may not agree with the proposition in Nandy's case.

1 Himansu Sekhar Nandy v DM Balasore, (1974) 4 CLT 1262

II. Expand scope of good faith exception

The other option to consider is the 'good faith exception' provided in most laws. Almost all laws dealing with narcotics provide immunity from prosecution if the action in question is under the colour of law and is undertaken in good faith.

There are two types of acts that are protected on the basis of bona fide intent or good faith. Firstly there are provisions that protect the government and government servants for acts done in good faith in exercise of powers and discharge of duties or functions under the drug laws or the rules made thereunder.

It is a moot question whether IDU harm reduction programmes would be considered acts done in good faith under the law. However, if harm reduction is seen as a constituent of drug treatment or believed to be so in good faith by the government officer, then this exception may be invoked to safeguard programme functionaries. Once again, given that interpretation of law rests on individual predilection of judges, it is hard to predict whether and to what extent, the good faith argument would be accepted in Courts.

Good faith exceptions also appear in the general criminal law including in the Penal Codes of Bangladesh, India, Pakistan and Sri Lanka. However, a closer look at the Codes shows that the exception is specific and applied in restricted circumstances. Immunity is accorded to acts, otherwise unlawful, but done in good faith, with respect to (1) a person who is not in a position to consent to the act in question and, (2) the act results in harm to such person.

III. Protect interventions by non-obstante clause

If harm reduction measures are not included within the rubric of treatment, or cannot be protected under the good faith exception,

legislative amendment may be required to allow harm reduction programmes to operate without legal intrusion.

There are different ways of doing this, the most obvious being to provide 'safe havens' for conducting interventions within the drug law itself. Thus, statutes could incorporate a non-obstante clause to declare that notwithstanding the provisions of the drug law or any other law for the time being in force, no activity or programme being undertaken for harm reduction whether by a service provider, like an NGO or government, or by a recipient of those services, that is the drug user, would be held criminally or civilly liable. Such a provision would protect, say, an outreach worker dispensing sterile syringes to IDUs from charges of aiding and abetting illicit drug consumption. IDU clients would, however, be exempt from penalties only for restricted acts to access prophylaxis at the harm reduction site and continue to be liable to prosecution for drug consumption.

In terms of legislative process, introducing a non-obstante clause is fairly simple. However, it calls for strong political will on the part of law and policy makers to introduce such a provision. It bears noting that a number of harm reduction measures are being carried on because already, enforcement authorities see the logic of pursuing them and the futility of invoking legal provisions to halt such expedient health interventions. Legal protection through a non-obstante clause will help facilitate, strengthen and expand harm reduction projects to reach populations imperiled by IDU and HIV/AIDS.

IV. Treat trafficker and user differently

As discussed earlier, possession, use and consumption of a narcotic substance is a penal offence in all SAARC countries. This is, on account of the international drug conventions that mandate signatories to criminalise possession and consumption. However, the conventions allow

certain flexibility leaving it open for signatory states to criminalize possession, use or consumption differently on the basis whether the accused is an addict or a supplier of illicit drugs. While it is necessary and desirable to punish traffickers, application of the same punitive standards to drug users is now increasingly being questioned.

Accordingly, some countries in the region have made a distinction between these two categories by prescribing differential penalties, attracted on the basis of the substance and the quantity in possession. Thus, possession of small quantity carries less stringent punishment as also possession of a "softer" drug such as cannabis as compared to heroin. Though not a perfect remedy, at the very least, such differential treatment should be encouraged as a legislative policy within the SAARC region.

V. Conduit treatment outside the criminal justice system

Laws in almost all SAARC countries contain benign provisions for drug users, which may broadly be described as - (1) an offer of immunity from prosecution, (2) allowing convicts to opt for treatment in lieu of punishment or, (3) permitting person charged with an offence either relating to possession, use or consumption to enroll in drug treatment. Unfortunately, these provisions only apply to "addicts", to the exclusion of initial users or those experimenting with drugs, who may not have developed physical dependence yet but nevertheless require immediate attention and social support. On the contrary, intimate contact with hardened drug users in jails may

worsen substance abuse. Extending non-punitive provisions to first time users would then prevent them from sinking deeper into drug addiction/dependence.

Furthermore, even in countries where the law clearly lays down treatment as an alternative to penalties, diversion of drug users from prison to treatment centers is infrequent. In other words, sentencing is the routine or the rule. There is no reason why, for a drug user, treatment should not be the first rule and sentencing the alternate option. This calls for a paradigm shift in thinking of drug users as persons who need medical assistance and not a jail sentence.

The criminal justice system hardly offers opportunities for treatment and recovery; instead it ordains a life of crime, prison and social marginalisation for individuals struggling with drug dependency. Across the region, few prisons have drug detoxification and treatment facilities; still fewer have harm minimization services in place. Where available, entry into prison based drug treatment is conditional and often requires abstinence from drugs resulting in marginal relief from craving, incomplete recovery and frequent relapse. The stigma associated with criminal conviction and imprisonment adds to the social marginalisation that drug users experience as 'junkies'. Chances of economic and social recovery shrink further for convicted drug users. Universally, drug users' experiences with penal and corrective institutions have been far from encouraging. It is time that treatment in civil institutions be recognized as the dominant mode to address drug use and dependence.

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