THAILAND

Deadly Denial

Barriers to HIV/AIDS Treatment for People Who Use Drugs in Thailand

HUMAN RIGHTS WATCH

TTAG
THAI AIDS TREATMENT ACTION GROUP
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Executive Summary and Recommendations

> The doctor said if I use drugs, I can't have ART.
> —Chai L., age 45, HIV-positive drug user

Thailand is one of the few developing countries to have successfully curbed a runaway HIV/AIDS epidemic, cutting the number of new infections by almost 80 percent since 1991. Among injection drug users, however, prevalence has not dropped, and remains at nearly 50 percent—virtually unchanged over the past two decades.

Thailand is also a global leader among developing countries in providing antiretroviral therapy (ART), with more than 180,000 people living with HIV/AIDS on ART by mid-October 2007. More than 80 percent of people in need of ART in Thailand are receiving it, making it one of three developing countries worldwide–and the only one in Asia–to achieve this level of coverage.[1] Thailand has also been hailed as a model with regard to its efforts to provide antiretroviral drugs to HIV-positive women to prevent mother-to-child transmission, reaching 89 percent of women who need it. Yet despite repeated proclamations to provide access to antiretroviral treatment to *all* who need it, the government of Thailand has failed to systematically extend treatment to drug users.

Thailand has refused to implement proven, evidence-based strategies to reduce HIV risk among drug users as promoted by the World Health Organization, UNAIDS, and the UN Office on Drugs and Crime. It has in the past systematically blocked access to HIV treatment for drug users. Most pointedly, in 2003 the Thai government launched a repressive and inhumane "war on drugs" that included thousands of extrajudicial killings of alleged drug users or dealers, and drove drug users further underground and away from effective HIV/AIDS prevention or treatment. The result of these policies is an HIV epidemic among drug users that mars Thailand's reputation as a success story in the global fight against AIDS. Indeed, the Thai government has

1 The other two countries are Botswana and Brazil.

publicly acknowledged that the HIV infection rate among people who use drugs "has sustained itself at an unacceptably high level in Thailand."

In response to advocacy by people who use drugs, the Thai government has taken steps to reduce some of the barriers to health services. In 2004, for example, the Thai government rescinded a national policy that explicitly permitted the exclusion of injection drug users from ART programs.

Thailand has repeatedly pledged to address its failures to prevent HIV infection or extend treatment to drug users. In its report to the United Nations General Assembly Special Session (UNGASS) on HIV/AIDS in 2006, the Royal Thai Government acknowledged that "little has been done to address specific challenges" of providing HIV testing and counseling, care and support, and ART for injection drug users, and acknowledged that it should "act quickly" to scale up outreach, related harm reduction, ART, and other HIV/AIDS services for injection drug users. At the Special Session itself, the government pledged to promote and implement HIV prevention and harm reduction services for all those who need them, to increase access to methadone maintenance, and to enable and empower drug users to take measures to reduce unsafe injecting practices and to enter treatment programs. The government's 2007-2011 National AIDS Plan, introduced in June 2007, again recognized its failures to address HIV and AIDS among drug users and renewed its commitments to ensure HIV and AIDS services to them.

Research by Human Rights Watch and the Thai AIDS Treatment Action Group (TTAG) found, however, that drug users still face serious obstacles to obtaining needed care. Many healthcare providers either do not know or do not follow the revised HIV/AIDS treatment guidelines and therefore continue to deny antiretroviral treatment to people who need it based on their status as drug users, even if they are in methadone treatment programs. HIV and drug treatment care providers are grossly under-informed and untrained in issues central to the appropriate care and treatment of people who use drugs, and they continue to let their negative attitudes toward people who use drugs inhibit drug users' right to healthcare services. For example, some healthcare providers denied drug users access to ART because of an erroneous conviction that the treatment would be "wasted" on "unreliable" drug

users who would fail to adhere to medication, develop resistance to it, or spread drug-resistant HIV strains.

HIV clinicians and drug treatment providers reported that they did not have the knowledge or training they needed concerning interactions between ART and methadone or illicit drugs and the associated consequences. Reflecting another dimension of the same problem, Human Rights Watch and TTAG also found that drug users who do receive ART are unlikely to tell their physicians about their drug use, or to seek information about drug dependence treatment from their ART provider, out of fear of reprisal. This fear is not unfounded: our research confirms that many public hospitals and clinics share information about drug use with law enforcement, both as a matter of policy and in practice. Some ART providers operated a "don't ask, don't tell" policy toward drug users, refusing to inquire about patients' drug use or drug treatment history, in some cases despite knowledge or suspicion of current drug use or methadone treatment.

In this setting, information sharing between drug users and clinicians is a dangerous "catch-22": in a context where police both formally and covertly gain access to hospitals' information about individual drug users, drug users as well as sympathetic healthcare workers have good reason not to disclose any information about drug use. However, failure to ensure conditions in which safe exchange of information is possible can compromise drug users' access to adequate HIV and other healthcare services, and can expose ART recipients to dangerous drug-drug interactions.

International experience has shown that, with adequate support, people who use drugs can adhere to ART regimens and benefit from other HIV care at rates comparable to non-drug users. The World Health Organization, UNAIDS, and the UN Office on Drugs and Crime have recommended that a comprehensive package of linked services—including general medical care, drug dependence treatment, and psychosocial support—is crucial in the treatment of drug users living with HIV/AIDS. Integrated services appropriate to people who use drugs are not provided to drug users in Thailand.

International agencies have also advocated strongly for strategies that reduce the harms associated with illicit drugs even for those unable or unwilling to stop using those drugs. Harm reduction strategies include targeted interventions, often through peer outreach and education, such as the provision of sterile injecting equipment, methadone maintenance therapy, and HIV testing and counseling. All of these actions have proved effective in preventing HIV transmission and other adverse consequences of drug use without increasing drug use or drug-related crimes. These approaches have also been internationally recognized as a key entry point to the healthcare system for people who use drugs.

The Thai government has provided minimal support for harm reduction services for people who use drugs, notwithstanding their proven effectiveness. Basic harm reduction programs for injection drug users such as syringe exchange remain a major point of contention, with government officials ignoring the calls of nongovernmental organizations for such services in favor of abstinence-based approaches to drug use.

Moreover, the limited harm reduction programs available in Thailand are seriously undermined by the government's ongoing, repressive anti-drug campaigns. Police regularly interfere with drug users' health-seeking efforts by harassing clients outside drug treatment centers and by using the possession of sterile syringes or presence at a methadone clinic as a basis for drug charges. A police superintendent in Chiang Mai acknowledged that his office maintained a blacklist of suspected drug users, and said that possession of clean needles, while legal, was a basis for questioning someone on the blacklist. Many government officials seem to be unaware of the fact that it is legal to possess syringes in Thailand. Ministry of Public Health representatives, physicians providing HIV/AIDS and drug treatment services at government clinics, and law enforcement officials told Human Rights Watch that syringe exchange was illegal or impracticable in Thailand, notwithstanding international guidance to the contrary. Many government authorities see needle and syringe exchange programs as "immoral," "foreign," "not Thai, or not appropriate for Thailand," or "encouraging drug use." As a result, peer outreach workers are forced to conduct sterile syringe exchanges underground and are routinely harassed by the police.

The harassment of peer outreach workers has a direct impact on the health and lives of drug users. Many identified their peers as the most important—if not sole—source of HIV-related information, counseling, and support for HIV testing and obtaining basic HIV-related health care and drug treatment. Likewise, the harassment of drug users directly impacts the effectiveness of peer outreach programs.

Many Thai drug users spend time in pretrial detention or prison, often repeatedly. But in custodial settings drug users have an even harder time obtaining needed HIV prevention, care, and treatment services. Thailand has no national guidelines on ensuring access to ART on entry to or exit from prison. Human Rights Watch and TTAG found that antiretroviral therapy was available only on an extremely limited basis to Thai prisoners. Further, we found that the Thai government has failed to take measures to ensure that fundamental services (medical care, harm reduction, drug dependence treatment, psychosocial support) are coordinated in the general community, or with services provided on entry to or exit from prison. All of these services are a critical part of comprehensive HIV care for drug users.

Thailand's failure to ensure equal access to antiretroviral treatment to drug users, and to ensure access to harm reduction services violate its constitutional obligations to provide "quality public health services" and protection "against dangerous infectious diseases" "free of charge and in a timely fashion."

Thailand's failure to ensure comprehensive HIV/AIDS services to drug users according to international standards violates its obligations to respect and fulfill the right to health. Refusal to provide ART based on an individual's drug user status violates the right to non-discrimination. The failure to create conditions to promote open exchange of information about drug use, and to protect the confidentiality of information about drug use, compromises fundamental rights to information and to health, and may violate the right to privacy.

Thailand needs to take urgent steps to address the various failings identified in this report. Human Rights Watch and the Thai AIDS Treatment Action Group make the following key recommendations:

Recommendations

To the government of Thailand

Increase harm reduction services for drug users:

- Develop a clear national harm reduction policy, consistent with international standards, in consultation with high-level officials from the Ministry of Public Health, the Office of the Narcotics Control Board, the Ministry of Interior, the Ministry of Justice, the National Police Office, the Prime Minister's office, Thai and regional non-governmental HIV/AIDS and harm reduction organizations, relevant United Nations officials and offices (such as the Joint United Nations Programme on HIV/AIDS (UNAIDS)), the U.N. Special Envoy for HIV/AIDS in Asia, and the United Nations Office on Drugs and Crime) and people who use drugs
- Establish and integrate needle and syringe exchange, methadone maintenance therapy, and other evidence-based harm reduction interventions into the existing Continuum of Care Centers in Thailand.
- Ensure that drug users have access to harm reduction services, including methadone and sterile syringes, and that cost or fees are not a barrier to such access. This would be consistent with the constitutional provision that all persons shall be protected "against dangerous infectious diseases" "free of charge and in a timely fashion."
- Establish clear, time-bound targets for extending the provision of low-threshold harm reduction services to all parts of the country.

Take concrete steps to reduce drug users' fear of seeking health services:

- Immediately and publicly declare that drug users seeking health services will not be penalized or forced into drug treatment based solely on their identification as drug users, and amend relevant laws and policies to ensure prompt compliance with this policy.
- Provide basic training to police on HIV/AIDS prevention, care, and treatment, and the importance of harm reduction in the fight against HIV/AIDS.
- Take active steps to address drug users' distrust of public health services. This should include concrete measures to ensure that information about

patient drug use provided in the course of medical care is not shared with law enforcement officials and to establish and sustain active cooperation with harm reduction programs and outreach workers.

- Train healthcare providers in the appropriate care and treatment of people who use drugs. This should include human rights training to reduce stigma and discrimination against people who use drugs.

Take concrete steps to ensure drug users' rights to information:

- Ensure that drug users, healthcare providers, and law enforcement officers have complete, accurate information about ART, HIV/AIDS, and harm reduction services, and information about drug users' rights to these services.
- Ensure that drug users can obtain ART, harm reduction, and other HIV/AIDS information and services without fear of punishment or discrimination.
- Expand and enhance the scope of and support for ART, harm reduction, and other HIV/AIDS information and services including voluntary HIV testing and counseling for people in prison and other places of detention.
- Provide information and training to healthcare providers about basic principles and practices of providing antiretroviral treatment to injection drug users, including about adherence support; drug-drug interactions; and co-infection, such as with tuberculosis and hepatitis C.
- Provide information and training to drug users about HIV/AIDS-related services, including ART, drug interactions, tuberculosis, and hepatitis C.
- Provide support for peer outreach and education workers, including as counselors for HIV testing, ART adherence support, and harm reduction.
- Establish and strengthen communication among relevant ministries (including the Ministry of Public Health, the Office of the Narcotics Control Board, the Ministry of Interior, the Ministry of Justice, the National Police Office, and the Prime Minister's office).

Address structural barriers to care:

- Adopt and disseminate a clear national policy to ensure coordination of basic services for drug users (HIV/AIDS services, harm reduction, drug treatment, psychosocial support) and ensure that such services are coordinated between those provided in the community and in custodial settings.

- Develop effective referral systems between HIV, drug treatment, and other relevant services to link community and custodial settings.
- Ensure that people who use drugs enjoy an equal right to receive public health and welfare services, and protection against disease. The Thai constitution provides that there should be guaranteed access to public health and social welfare services.

To the government of the United States

- Lift the ban on U.S. funding for syringe exchange program services.
- Officially recognize the importance of harm reduction in preventing HIV/AIDS and other infectious diseases, and encourage and support international efforts to implement harm reduction interventions, including measures to ensure access to sterile syringes.

To the United Nations and International Donors to Thailand

- Relevant United Nations agencies (including UNAIDS, WHO, UNODC, the U.N. Special Envoy for HIV/AIDS in Asia, and the U.N. Special Rapporteur on the Right to Health) and international donors to Thailand should take steps to ensure that Thailand promptly and immediately adopt concrete measures to address drug users' fear of seeking health services, and that Thailand promptly and immediately meet its public commitments to ensure harm reduction, ART, and other HIV/AIDS services for drug users.

Methods

This report is based on information collected during field investigations in Thailand in June-July and November-December 2006. Two Thai AIDS Treatment Action Group (TTAG) staff members and a Human Rights Watch staffer conducted detailed individual interviews with 43 current and former drug users and spoke more informally with two groups of drug users at drop-in centers for methadone patients and for people living with and at high risk of HIV/AIDS. The interviews took place in Chiang Mai, Bangkok, Samut Prakhan, Songkhla, and Satun provinces, five diverse provinces with high concentrations of injection drug users. Interviews were conducted either in Thai or with translation to and from English. Interviews with drug users were arranged through nongovernmental organizations (NGOs) providing services to drug users living with and at high risk of HIV/AIDS. These interviewees may therefore have had greater access to harm reduction and HIV/AIDS services than the general population of people affected by HIV/AIDS. The identity of these interviewees has been disguised with pseudonyms and in some cases certain other identifying information has been withheld to protect their privacy and safety.

Additional interviews were also conducted in Thai or with Thai-English translation with healthcare workers providing HIV/AIDS care and/or drug treatment services, including chief medical staff at Thailand's largest prison, and the directors and staff of the two largest government inpatient drug treatment centers and a major government inpatient compulsory drug treatment center; high-level officials in the Office of the Narcotics Control Board, the Ministry of Public Health at national and provincial levels; local police; representatives of domestic and international NGOs working with drug users and people living with HIV/AIDS; and United Nations (UN) officials. All documents cited in the report are either publicly available or are on file with Human Rights Watch and TTAG.

Background

Thailand as an HIV/AIDS "Success Story"

Thailand is one of the few developing countries to have successfully curbed a runaway HIV/AIDS epidemic, cutting the number of new infections by almost 80 percent since 1991.[2] It is a global leader among developing countries in providing antiretroviral therapy (ART), with more than 180,000 people living with HIV/AIDS on ART by mid-October 2007.[3] More than 80 percent of people in need of ART in Thailand are receiving it, making it one of three developing countries worldwide–and the only one in Asia–to achieve this level of coverage.[4] Thailand has also been hailed as a model with regard to its efforts to provide antiretroviral drugs to HIV-positive women to prevent mother-to-child transmission, reaching 89 percent of women who need it.[5]

HIV/AIDS and Injection Drug Use in Thailand

In stark contrast to other groups at risk of HIV, such as sex workers and military recruits, HIV prevalence among Thailand's injection drug users has never shown significant decline.[6] Injecting drug users were Thailand's "first wave" of HIV infection. HIV prevalence among this group skyrocketed from virtually nil to 40 percent in a single year when it was first identified in 1987-88.[7] The consequences of Thailand's

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2 United Nations Development Programme (UNDP), Thailand Human Development Report 2007 (Bangkok: United Nations Development Programme, 2007), p. 2.

3 Email communication from Dr. Sanchai Chasombat, Department of Disease Control, Ministry of Public Health, Thailand to TTAG, October 18, 2007.

4 World Health Organization, UNAIDS, UNICEF, Towards Universal Access: Scaling Up Priority HIV/AIDS Interventions in the Health Sector: Progress Report, April 2007 (Geneva: World Health Organization, 2007), p. 15. The other two countries are Botswana and Brazil.

5 Ministry of Public Health, Thailand, and World Health Organization Regional Office for South-East Asia (WHO-SEARO), External Review of the Health Sector Response to HIV/AIDS in Thailand (New Delhi: WHO Regional Office for South-East Asia, 2005), p. 35.

6 See, for example, Chris Beyrer et al., "Drug Use, Increasing Incarceration Rates, and Prison-Associated HIV Risks in Thailand," AIDS and Behavior, vol. 7, no. 2, June 2003, p. 153, citing Ministry of Public Health, Thailand, HIV/AIDS Sentinel Surveillance Report (Bangkok, 2000).

7 World Bank, "Thailand Social Monitor: Thailand's Response to AIDS: Building on Success, Confronting the Future," November 30, 2000, http://wwwwds.worldbank.org/external/default/WDSContentServer/WDSP/IB/2002/03/29/000094946_02031904060482/

failure to adopt harm reduction strategies immediately, despite the government's awareness of their effectiveness as determined by local studies (see below), can be measured in the sustained high HIV infection rates among injection drug users to date. The Thai Working Group on HIV/AIDS Projections estimated in 2001 that with a significant investment in programs that reduced needle-sharing among injection drug users, the number of new HIV infections in Thailand could drop from 29,000 in 2000 to 11,800 in 2006. Without such an investment, the number of new infections in 2006 would be 17,000[8] -- approximately the number of new infections reported in 2006.[9]

The UNDP reported in 2004 that one-quarter of all new infections occurred among injecting drug users.[10] At a high-level UN meeting on HIV/AIDS in 2006, the Thai government publicly expressed concern about the HIV infection rate among people who use drugs, acknowledging that it had "sustained itself at an unacceptably high level in Thailand since the very beginning of the epidemic."[11]

By 2003 HIV prevalence among injection drug users at Thailand's addiction clinics stood at approximately 45 percent, exceeding the 1988 levels.[12] Prevalence among injection drug users may be as high as 60 percent in some regions, according to sentinel surveillance conducted in 39 sites in 2000.[13] An estimated 3 to 10 percent of

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Rendered/PDF/multiopage.pdf (accessed November 5, 2007), p. 5. HIV spread rapidly among networks of injection drug users in Thailand in the late 1980s, with clear links to incarceration. Ibid.

8 Thai Working Group on AIDS Projections, Projections for HIV/AIDS in Thailand (Bangkok: Ministry of Public Health, Thailand, 2001), p. xvii.

9 The Thai Ministry of Public Health estimates the number of new HIV infections in 2006 to have been approximately 17,000. See Pongphon Sarnsamak, "HIV Rate Rises in Married Couples," The Nation, October 11, 2007 (reporting 7000, or 40 percent of new infections, of new infections in 2006 among married couples, and thus about 17,500 total infections).

10 UNDP, Thailand's Response to HIV/AIDS: Progress and Challenges (Bangkok: UNDP, 2004), p. 54.

11 Thailand Ministry of Public Health, "Towards Universal Access by 2010: Thailand National HIV and AIDS Program," 2006.

12 Warunee Punpanich et al., "Thailand's Response to the HIV Epidemic: Yesterday, Today, and Tomorrow," AIDS Education and Prevention, Supplement A, June 2004, pp. 119-136.

13 UNAIDS, "Epidemiological Fact Sheet on HIV/AIDS and Sexually Transmitted Infections: Thailand" (2002). Sentinel surveillance for HIV/AIDS is the unlinked and anonymous testing of blood for the purpose of monitoring the prevalence and trends in HIV infection over time and place in a given population. WHO Regional Office for South-East Asia, "Tuberculosis and HIV: Some Questions and Answers," http://www.searo.who.int/en/Section10/Section18/Section356/Section421_1623.htm (accessed November 2, 2007).

injection drug users are newly infected each year, chiefly through contaminated injection equipment.[14]

Thailand has made a number of public commitments to address its failure to combat HIV/AIDS among drug users that have, to date, remained unfulfilled. In its 2006 report to the United Nations General Assembly Special Session (UNGASS) on HIV/AIDS, the Royal Thai Government acknowledged that "little has been done to address specific challenges" of providing HIV testing and counseling, care and support, and ART for injection drug users, and acknowledged that it should "act quickly" to scale up outreach, related harm reduction, ART, and other HIV/AIDS services for injection drug users.[15] At the Special Session itself the government pledged to promote and implement HIV prevention and harm reduction services for all those who need them to increase access to methadone maintenance, and to enable and empower drug users to take measures to reduce unsafe injecting practices and to enter treatment programs.[16] And in its 2007-2011 National AIDS plan, introduced in June 2007, Thailand recognized its failures to address HIV/AIDS among people who use drugs, and renewed its pledge to scale up efforts to ensure access to HIV/AIDS prevention, care, and treatment services to them.[17]

An estimated 3 million people (5 percent of the population) use drugs in Thailand. While the majority of drug users take methamphetamines, an estimated 100,000 to 275,000 use heroin, 80 percent of whom inject. In 2003 the Thai government launched a "war on drugs" campaign, which is discussed below. Studies suggest that one unintended consequence of this war on drugs may have been increased

14 UNAIDS, AIDS Epidemic Update, 2006 , p. 33.

15 Submission by Royal Thai Government to UNAIDS, , "Follow-up to the Declaration of Commitment on HIV/AIDS (UNGASS) Country Report," 2006, p. 19, http://www.unaids.org/en/Publications/2005ungassreporting/default.asp (accessed November 5, 2007).

16 Thailand Ministry of Public Health, "Towards Universal Access by 2010: Thailand National HIV and AIDS Program," 2006.

17 Thailand Ministry of Public Health, Department of Disease Control, Book 1: National Plan for Strategic and Integrated HIV and AIDS Prevention and Alleviation 2007-2011: Key Contents (National Committee for HIV and AIDS Prevention and Alleviation, 2007), pp. 8, 11-15, 19, 28, 30.

injection of sedatives (particularly midazolam) among heroin injectors.[18] Injection of methamphetamines, opium and cocaine has also been reported.[19]

Narcotic Drug Law and Policy in Thailand

Thai law and policy regarding drug users has only recently begun to reflect the international consensus that drug dependence is an illness to be treated, and not a crime to be punished.

As far back as 1991 a Bangkok Metropolitan Administration study showed that patients on "methadone maintenance" (in this case, 180 days) were much less likely to return to heroin use than those on a "methadone detoxification" program (here, 45 days).[20] However, it was not until 2001 that the Ministry of Public Health changed its policy to allow for methadone maintenance, and even then limited treatment to a maximum of two years.[21]

The number of people incarcerated in Thailand more than tripled between 1992 and 2001, largely due to tough drug policies.[22] By February 2002, there were 250,000 people incarcerated in correctional facilities throughout Thailand – almost three times official capacity[23]—and nearly two-thirds of those in prison were drug offenders.[24] In 2002, to address serious problems associated with prison

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18 Vichai Poshyachinda et al, "Illicit substance supply and abuse in 2000-2004: an approach to assess the outcome of the war on drug operation," Drug and Alcohol Review , September 2005, p. 465.

19 United Nations Office on Drugs and Crime, Regional Centre for East Asia and the Pacific (UNODC-SEARO), "Patterns and Trends of Amphetamine-Type Stimulants and Other Drugs of Abuse in East Asia and the Pacific 2005," June 2006, http://www.apaic.org/dc/Patterns_and_Trends_2005.pdf (accessed November 5, 2007), p. 103.

20 Ainsworth et al., Thailand's Response to AIDS, p. 45.

21 UNODC-SEARO, "Drugs and HIV/AIDS in South East Asia: A Review of Critical Geographic Areas of HIV/AIDS Infection among Injecting Drug Users and of National Programme Responses in Cambodia, China, Lao PDR, Myanmar, Thailand and Viet Nam," February 2004, http://www.unodc.un.or.th/drugsandhiv/publications/2004/5_hivaids.pdf (accessed November 5, 2007), p. 38.

22 R. Walmsley, "World Prison Brief. Prison Population for Thailand," 2005, http://www.kcl.ac.uk/depsta/rel/icps/worldbrief/continental_asia_records.php?code=114Population List (6th ed.) (accessed August 26, 2007).

23 Kanokpun Kalyanasuta and Atchara Suriyawong, "The Criminal Justice System and Community-Based Treatment of Offenders in Thailand," Paper presented at the 121st International Training Course. Resource Material Series No. 61, pp. 265-293. Tokyo: United Nations Asia and Far East Institute For the Prevention of Crime and the Treatment of Offenders (2002), pp. 273-274.

24 Ibid., p. 273.

overcrowding, Thailand amended its Narcotic Addict Rehabilitation Act to provide alternatives to incarceration for some drug offenses.[25] The law, which considers "drug addicts" as "patients," and not "criminals," provides for up to six months compulsory treatment (in lieu of incarceration), renewable for up to three years, for "drug users" or "drug addicts" found to have used or been in possession of small quantities of illicit drugs. After rehabilitation, a committee appointed by government authorities considers whether a person has been "rehabilitated," or whether criminal proceedings should be instituted.[26]

But Thailand's harsh drug control laws have not been amended to accommodate the spirit of the 2002 Narcotic Addict Rehabilitation Act. Thai narcotics law criminalizes the possession of extremely small amounts of drugs for personal use and gives wide powers of search, seizure, and arrest to the police.[27] The Thai government provides significant financial resources to local communities to assist with identification and reporting of drug users and dealers. According to Pithaya Jinawat, deputy secretary general of the Office of the Narcotics Control Board (ONCB)(the coordinating and policy-making bureau for drug control efforts), the ONCB actively recruited villagers to assist ONCB with local-level surveillance of drug users and dealers and to share information about drug use and drug users with them. Jinawat said that 200 million baht[28] had been allocated to village committees to assist with local-level surveillance, and that more than 10,000 villages (out of 85,000) were involved this work.[29]

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25 Narcotic Addict Rehabilitation Act, B.E. 2545 (2002). See also Mikinao Kitada, director, United Nations Asia and Far East Institute for the Prevention of Crime and the Treatment of Offenders, "Prison Population in Asian Countries: Facts, Trends and Solutions," paper presented at UN Programme Network Institute's Technical Assistance Workshop, Vienna, Austria, May 10, 2001, p. 8; and Ampa Santimetanedol,"Faster executions, but amnesties for minor crimes," Bangkok Post, March 15, 2001.

26 Human Rights Watch is concerned that the powers granted to sub-committees authorized under the Narcotic Addict Rehabilitation Act to may violate guarantees under the International Covenant on Civil and Political Rights with respect to right to liberty (Article 9) and the right to a fair hearing before a competent, independent and impartial tribunal (Article 14) as the committees include non-judicial officials and individuals who may not be independent, and yet exercise authority to determine the eligibility of a defendant for rehabilitation and release under the law.

27 See, e.g., Narcotics Control Act of B.E. 2519 (1976), section 14, as amended by the Narcotics Control Act (No. 3), B.E. 2543 (2000) and the Narcotics Control Act (No. 4), B.E. 2548 5 (2002); Narcotics Act of B.E. 2522 (1979), chapters 2, 8, 10, 12 (as amended by the Narcotics Act (No. 5), B.E. 2545 (2002).

28 On July 1, 2006, 200 million baht was US $5,236,530.

29 Human Rights Watch and TTAG interview with Pithaya Jinawat, Bangkok, July 25, 2006.

Since 2003 the government of Thailand has periodically declared successive rounds in its "war on drugs," which in its earliest stages involved arbitrary and brutal practices including at least 2,275 extrajudicial killings of alleged drug users or dealers.[30] In its investigation into killings in the first phase of the war on drugs, the National Human Rights Commission found that the victims were mostly innocent persons whose deaths in 2003 had never been properly investigated, and that some of the murders plainly had been set up by the police.[31] In its 2005 report on Thailand, the UN Human Rights Committee expressed concern over "the extraordinarily large number of killings during the 'war on drugs' which began in February 2003," and government failure adequately to investigate these killings, or prosecute and punish the alleged perpetrators.[32]

Four-and-a-half years after the first and most violent phase of the war on drugs, and more than two years after the Human Rights Committee issued its findings, the government has just begun to conduct full and impartial investigations into the killings, and institute proceedings against their perpetrators. In August 2007 Thailand's interim military government appointed six sub-panels to investigate the extrajudicial killings in the 2003 war on drugs and to analyze the impact of the drug suppression policies implemented during that regime, ostensibly to prevent violations from occurring again.[33]

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30 See Order of the Prime Minister's Office No. 29/B.E. 2546 (2003), "A Fight to Overcome Drugs;" Y. Tunyasiri and W. Ngamkham, "Thaksin orders new round of suppression," Bangkok Post, February 29, 2004; Order of the National Command Center for Combating Drugs (NCCD) No. 6/B.E. 2547 (2004), "Kingdom's Unity for Victory Over Drugs," NCCD Order No. 24/B.E. 2547 (2004), "Second Kingdom's Unity for Victory Over Drugs;" " Anti-Narcotics Campaign: PM Launches New Round In War On Drugs," The Nation, April 12, 2005; ONCB, Roadmap of Drug Surveillance and Establishment of Sustainable Victory over Drugs 2006-2008," March 24, 2006, http://en.oncb.go.th/document/Roadmap06-08.pdf (accessed November 12, 2007). Human rights abuses in the "war on drugs" are documented in Human Rights Watch, Not Enough Graves: The War on drugs, HIV/AIDS, and Violations of Human Rights, vol. 16, no. 8(c), June 2004, http://hrw.org/reports/2004/thailand0704/thailand0704.pdf.

31 See Statement by Asian Human Rights Commission, "Thailand: Investigate institutions that kill, not just killers," November 23, 2006.

32 UN Human Rights Committee, "Consideration of Reports Submitted by States Parties under Article 40 of the Covenant, Concluding Observations, Thailand," CCPR/CO/84/THA, July 8, 2005, http://www.unhchr.ch/tbs/doc.nsf/898586b1dc7b4043c1256a450044f331/e860ca7730edc51ec125706900453a28/$FILE/Go543504.pdf, para. 10.

33 Supawadee Inthawong, "Drug War Inquiry Chiefs Named," Bangkok Post, August 30, 2007.

Providing HIV Care and Treatment to People Who Use Drugs: General Principles

International experience has demonstrated that with adequate support, people who use drugs can adhere to antiretroviral treatment regimens and benefit from other HIV care at rates comparable to non-drug users.[34] Drawing on this experience, the World Health Organization (WHO), the United Nations Office on Drugs and Crime (UNODC), and UNAIDS have identified important principles governing the delivery of HIV care and treatment to people who use drugs to facilitate their optimal access and adherence to antiretroviral therapy, which are summarized below.[35] Thailand's constitution and its national HIV/AIDS policies recognize these principles and their importance toward reaching the national goal of universal ART access.[36]

Antiretroviral treatment should be provided on an equitable basis to all who need it, based on internationally accepted clinical criteria. Current or past drug use should not be a criterion for deciding who should receive antiretroviral treatment.

Healthcare services should be comprehensive, and integrated with general medical care, harm reduction services, drug dependence treatment, and psychosocial support.

People who use drugs have proved effective as peer counselors and educators in facilitating and supporting HIV care and treatment to their peers, and should be involved in the design and delivery of integrated treatment programs.

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34 See Matt Curtis, ed., Delivering HIV Care and Treatment for People Who Use Drugs: Lessons from Research and Practice (New York: Open Society Institute, 2006), pp. 25-35.

35 This section draws on the following sources: WHO, UNAIDS, UNODC, "Evidence for action on HIV/AIDS and Injecting Drug Use. Policy Brief: Antiretroviral Therapy and Injecting Drug Users," WHO/HIV/2005.06; WHO Regional Offices for South-East Asia and the Western Pacific, "HIV/AIDS Care and Treatment for People Who Inject Drugs In Asia. A Guide to Essential Practice" (draft), December 2006; Matt Curtis, ed., Delivering HIV Care and Treatment for People Who Use Drugs; WHO, UNODC, UNAIDS, "Substitution maintenance therapy in the management of opioid dependence and HIV/AIDS prevention: Position paper," 2004; World Health Organization Regional Office for Europe, "HIV/AIDS Treatment and Care for Injecting Drug Users. Clinical Protocol for the WHO European Region."2006, pp. 5-24.

36 Constitution of Thailand, sections 51, 55; National Committee for Prevention and Solutions to AIDS Problems, "National Strategic Plan to Integrate Prevention and Solutions to AIDS Problems (2007-2011), Main Content (Book 1), 2007; National Committee for Prevention and Solutions to AIDS Problems, "National Strategic Plan to Integrate Prevention and Solutions to AIDS Problems (2007-2011): Details on Strategy, Standards, Approaches and Indicators and Responsible Agencies," 2007.

Open communication about drug interactions must be guaranteed. The WHO specifically advises healthcare providers to "counsel every patient on all possible interactions of ARVs with other drugs administered, including substitution therapy drugs, illicit/recreational drugs, and medications for tuberculosis, hepatitis B, hepatitis C, and opportunistic infections. Awareness of interactions and reporting and management of symptoms is critical for the patient's well-being, treatment adherence and effectiveness, and management of drug interactions."[37]

Viral hepatitis and tuberculosis should be addressed as components of HIV treatment and care. Co-infection with hepatitis B, hepatitis C, and/or tuberculosis is common among HIV-positive injection drug users. Healthcare workers providing HIV/AIDS treatment to drug users must understand the dynamics of co-infection with HIV and hepatitis B, hepatitis C, and tuberculosis, and be trained to provide appropriate diagnostics, treatment, and monitoring for these conditions.

Healthcare services should be coordinated with harm reduction programs. Harm reduction programs can be a key entry point to the healthcare system for people who use drugs, and have proved effective in improving uptake and adherence to HIV care and treatment for HIV-positive drug users. The WHO's South-East Asia and Western Pacific regional offices have recognized the important role that harm reduction programs have played in facilitating drug users' access to HIV care and treatment in Indonesia, where by mid-2006 91 syringe exchange programs and seven methadone programs (including one in prison) had been set up by the government.[38]

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37 World Health Organization Regional Office for Europe, "HIV/AIDS Treatment and Care for Injecting Drug Users. Clinical Protocol for the WHO European Region," pp. 5-24; see also WHO Regional Offices for South-East Asia and the Western Pacific, "HIV/AIDS Care and Treatment for People Who Inject Drugs In Asia," pp. 29-30. Human Rights Watch prefers the term "medication-assisted treatment" in place of "substitution therapy". Medication-assisted treatment (MAT) involves the administration of a substance like methadone or buprenorphine that is pharmacologically effective in treating the one causing dependence, usually provided in oral form, and under medical supervision. MAT prevents opiate withdrawal, decreases opiate craving, and diminishes the effects of illicit opiate use. Medicines used in medication-assisted treatment can be prescribed for short or long periods of time. MAT for opioid dependence (often called "opioid substitution therapy" or "substitution maintenance therapy"), through which patients receive a stable dose of methadone or buprenorphine over a long period of time, is one of the most effective and best-researched treatments for opiate dependence. Once a patient is stabilized on an adequate dose, he or she can function normally.

38 Ibid.

HIV/AIDS treatment and care must be provided in prisons and custodial settings as in the general community. Many drug users spend time in prisons or other closed settings such as police detention, compulsory drug treatment centers, or "rehabilitation" centers. In many countries the rates of HIV infection among prisoners and people in state custody are significantly higher than those in the general population. Incarcerated drug users may have begun drug dependence and/or HIV treatment prior to incarceration and face abrupt withdrawal and/or ART interruption while in custody. Prisons and closed settings thus present a key opportunity to address HIV/AIDS and drug dependence. Prisoners must be ensured access to comprehensive drug dependence and HIV-related services, including harm reduction, opioid medication-assisted therapy, and antiretroviral therapy. Ensuring continuity of services both on entry to and on release from prison is also critical.

Legislation, policies, and standards that enable implementation of effective services for drug users are key to ensuring access to healthcare services. Drug users throughout the world face a wide range of human rights abuses that put them at risk of HIV and other diseases, and impede their access to HIV/AIDS and other health care services to address them. Supportive legislation, regulations, policies, and attitudes that prevent the marginalization, discrimination, and stigmatization of drug users, and protect their human rights and dignity, are critical to ensuring access to comprehensive HIV/AIDS-related services for drug users.[39]

39 WHO Regional Offices for South-East Asia and the Western Pacific, "HIV/AIDS Care and Treatment for People Who Inject Drugs In Asia," pp. 7, 9,-10; UNAIDS, "Joint UNAIDS Statement on HIV Prevention and Care Strategies for Drug Users," June 2005, http://data.unaids.org/UNA-docs/cco_idupolicy_en.pdf (accessed November 2, 2007).

Findings

Drug Control Policy and Policing Practices Impeding Access to ART

In 1999 Chai L., an HIV-positive drug user, opened a drug treatment center in his village that provided drug treatment and HIV prevention, care, and treatment services for drug users, on an inpatient and outpatient basis. Chai recruited other drug users from the community (many of whom had attended a drug treatment center with him in another province, far from their home) to help build the center, and to work as peer counselors there. Chai coordinated his work with the local hospital methadone clinic, and promoted the clinic's work with peers in the community, including at religious centers.

During the 2003 war on drugs, an army officer who knew Chai came to Chai's center and took the patients to a "*wiwat polmeuang*," one of more than 40 military-run forced drug rehabilitation centers that had been set up by the government. The patients were needed to fill the center's quota. When Human Rights Watch and TTAG visited Chai in 2006, the treatment center that Chai had built with his peers in 1999, and that had served more than 300 patients, stood empty. Chai said, "Our center still exists, but the clients have disappeared during the drug war like [people disappeared] in the [2005] tsunami. My residents were forced to relocate to *wiwat polmeuang*." In the years since the 2003 drug war, some drug users have returned, "but as HIV-positive clients, because it's safer to come as an HIV-positive person than as a drug user."[40]

Although official policy in Thailand now emphasizes rehabilitation over punishment (treating low-level or first-time drug offenders as "patients" not "criminals"), drug users remain under surveillance by police and anti-drug agencies, and information about patient drug use is shared among public health and law enforcement agencies. As Human Rights Watch and others have documented, a lasting consequence of the war on drugs has been that drug users seeking protection from police violence, forced rehabilitation, and arrest were driven underground, away from critical health

40 Human Rights Watch and TTAG interview with Chai L., Satun province, July 10, 2006.

and support services, and put at increased risk of HIV.[41] Human Rights Watch and TTAG found that, as a result of these past and ongoing practices, many drug users avoid public healthcare services altogether, foregoing necessary health care or seeking treatment at private institutions where they are forced to pay for services that they are entitled to receive free of charge from the government.

Police Registration of Drug Users

Drug users and outreach workers said that the "war on drugs" has had a lasting detrimental effect on drug users' access to healthcare services, and that many drug uses would not seek treatment at public hospitals out of fear that information about their drug use (past or current) would be shared with the police. Indeed, public hospitals and drug treatment centers collect and share information about individuals' drug use with agencies including law enforcement as a matter of policy and practice.

When asked whether things had changed since a recent round in the war on drugs had been declared in May 2006, Lek L., a 28-year-old outreach worker in Chiang Mai, replied, "You can say it's better if you look at the number of people killed. What is worse is the number of people who fear and won't seek services." He continued that, as a peer outreach worker, he had learned that drug users' primary concern was that if they reported to any government office they would be "blacklisted," or registered as drug users, and their names would remain on the list.[42] At K., age 33, an HIV-positive peer educator in Chiang Mai, explained that HIV-positive drug users like him "would not go to the hospital unless we are dragged there." "The war on drugs has had an impact on me personally," At K. said, "The policy continues. HIV-positive injection drug users won't see the doctor because this policy has been there for too long and it's starting again now. My friends won't dare go to the hospital…. My friends say it's a state unit, it's a government office."[43]

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41 See, for example, Human Rights Watch, "Not Enough Graves: Human Rights and HIV/AIDS in the War on Drugs". See also UN Special Rapporteur on Right to Health July 24, 2004 communication to Thai government (expressing concern that the government's anti-narcotics campaign, coupled with limited access to harm reduction services "had inadvertently created the conditions for a more extensive spread of the virus in Thailand").

42 Human Rights Watch interview with Lek L.., Chiang Mai, July 12, 2006.

43 Human Rights Watch and TTAG interview with At K., Chiang Mai, July 15, 2006.

Drug users reported using private health clinics when seeking treatment for anything that might reveal their status as drug users (such as for treating abscesses or obtaining methadone.) Not only is this costly, but it also means that drug users are less likely to obtain information about government-funded HIV/AIDS services (including low-cost antiretroviral therapy) to which they are entitled.

It R., age 27, said that he was afraid to seek treatment at a public hospital for anything related to drug use, and that in mid-2006, when his friend had an injection-related injury, It R. took him to a private hospital for treatment. It R. explained that private hospitals did not ask for personal information and would not give it to police. "I am concerned that the state hospital would give information to the police. I feel more comfortable to pay more money than to risk my life."[44]

Ministry of Public Health and Office of the Narcotics Control Board officials explained that public hospitals registered information about active drug users on forms that were submitted via the internet to a central office at the Ministry of Public Health.[45] Rachanikorn Sarasiri, director of the ONCB's Foreign Affairs Bureau, explained that these forms were used "to monitor the drug use situation"; Sarasiri and her ONCB colleague further explained that this information was available to ONCB, to police involved with compulsory treatment, and in rehabilitation centers.[46] Gen. Bovorn Ngamkasem, consultant with the National Command Center for Combating Narcotic Drugs in the Ministry of Public Health, said that drug users' names also were shared with the local Ministry of Public Health and with members of the district committee, which included police. According to Ngamkasem, "If you come to the hospital with a broken leg and volunteer for [drug] treatment, they will put your name in the Ministry of Public Health network. This information is not given to police automatically, but if police ask for information about people who have been for drug treatment, they can get it."[47]

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44 Human Rights Watch and TTAG interview with It R., Chiang Mai, July 27, 2006.

45 Human Rights Watch interview with Gen. Bovorn Ngamkasem, Bangkok, July 19, 2006; Human Rights Watch and TTAG interview with Rachinikorn Sarasiri, director, Foreign Affairs Bureau, ONCB, July 25, 2006.

46 Human Rights Watch and TTAG interview with Rachinikorn Sarasiri, July 25, 2006; Human Rights Watch and TTAG interview with Sirima Sunavin, foreign relations officer, ONCB, July 25, 2006.

47 Human Rights Watch interview with Gen. Bovorn Ngamkasem, July 19, 2006. Ngamkasem expressed concern that information about drug users obtained by police was out of date, and that as a result some people were mistakenly identified

A police superintendent in Chiang Mai—the site of many extrajudicial executions during the 2003 "war on drugs"—acknowledged that his office maintained a blacklist of suspected drug users: "[W]ho was likely to be a user, an addict, or a dealer… Each *amphur* [district] must send their list to the provincial headquarters, which will then chase us up on whether those on the list have been arrested or not. They monitor us and follow up." The police lieutenant explained how they collected information about drug users from both state and private hospitals. "State hospitals must send us the names of users who seek treatment at hospitals in our zone. In the case of private hospitals we have to use other methods, for example send a policeman or a spy to get close to a member of the hospital staff and then ask who their patients are and where they live." When asked whether these surveillance practices affected drug users' access to healthcare services, the police superintendent replied, "For sure! Sometimes they are not ready to disclose that they are a drug user because the police will be told and then they will have to have a urine test at the station. If the test is positive they will be charged. If it's negative we put them under observation."[48]

Healthcare officials differed on the question of information sharing with police. Some officials at public hospitals acknowledged that they would report any drug user to police, and that this kept drug users from seeking antiretroviral treatment at public hospitals. For example, Dr. Anchalee Avihingsanon, an HIV clinician in Bangkok, said that hospitals were required to report active drug users to state officials, adding that "active drug users are afraid that they are going to get caught and sent to police or to a drug treatment program."[49] However, Thinmanee Tippanya, the chief of the drug abuse section of Chiang Mai's provincial health authority commented, "Drug users have told me that if they disclose information to health officers, they don't trust that the information won't be leaked to police. We say as a public health officer, our emphasis is on health, not detection of drug use." According to Tippanya, information about drug users arrested and subject to the 2002 Narcotic Addict Rehabilitation Act was routinely shared with police, but that

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as drug users. He said that he tried to get the police to update the information, out of concern that "some people referred by police have already stopped using drugs."

48 Human Rights Watch interview with police superintendent (name withheld), Chiang Mai, July 18, 2006.

49 Human Rights Watch interview with Dr. Anchalee Avihingsanon, trial physician and coordinator, HIV-NAT, Thai Red Cross AIDS Research Centre, Bangkok, July 20, 2006.

information disclosed about drug use during the course of voluntary health care or drug treatment would not be shared with police.[50]

In fact, pursuant to the 2002 Narcotic Addict Rehabilitation Act, the identity and other information about drug dependent persons referred for consideration under the Act is available to all persons assigned to enforce the Act, which includes representatives of the Ministry of Justice and the Department of Probation, as well as medical doctors, social workers, psychologists and in some cases, ex-drug users or people who work in Rehabilitation Centers.[51]

Tippanya added, "Personally, I think that drug users should disclose openly to health officers so they can get the right treatment and their health will improve. But they may have gotten the wrong information and fear that if they disclose to us, police will know. But as a public health officer, I tell people I do not disclose information about drug use to police." She acknowledged, however, that police nonetheless managed to get this information. "But of course, police have ways… They have their spies to get information."[52]

Preserving the confidentiality of medical information is protected by international law[53] as well as Thai law.[54] While the right to privacy does not establish an absolute rule of confidentiality of medical information, interference with this rule must be

50 Human Rights Watch and TTAG interview with Thinmanee Tippanya, Chiang Mai, July 14, 2006.

51 Narcotic Addict Rehabilitation Act, B.E. 2545 (2002), sections 6-13, 35; see also Human Rights Watch and TTAG interview with Neung P., Bangkok, July 21, 2006.

52 Human Rights Watch and TTAG interview with Thinmanee Tippanya, Chiang Mai, July 14, 2006.

53 The Economic, Social and Cultural Committee in its general comment 14, on the right to health, recognized "the right to have personal health data treated with confidentiality" (para. 12). More broadly, the committee noted that the "right to health is closely related to and dependent upon the realization of other human rights, as contained in the International Bill of Rights, including the right[] to … privacy" (para. 3). In citing to the right to privacy under article 19 of the International Covenant on Civil and Political Rights (ICCPR), the committee stated that it gave "particular emphasis to access to information because of the special importance of this issue in relation to health" (para. 12 fn. 8). According to Manfred Nowak in his treatise on the ICCPR, the right to privacy includes a right of intimacy, that is, "to secrecy from the public of private characteristics, actions or data." This intimacy is ensured by institutional protections, but also includes generally recognized obligations of confidentiality, such as that of physicians or priests. Moreover, "protection of intimacy goes beyond publication. Every invasion or even mere exploration of the intimacy sphere against the will of the person concerned may constitute unjustified interference" [emphasis in the original]. Manfred Nowak, UN Covenant on Civil and Political Rights: CCPR Commentary (Kehl am Rein: N.P. Engel, 1993), p. 296. The right to respect for a person's private life is also recognized in the European Convention on Human Rights and Fundamental Freedoms, article 8.

54 Criminal Code Sections 323-325; Information Act, BE 2540; Medical Council Code of Conduct BE 2526.

strictly justified. While limited information about patient drug use may be permitted in certain circumstances (for example, to establish patient compliance with compulsory drug treatment programs mandated pursuant to the 2002 Narcotic Addict Rehabilitation Act), such broad sharing of information about drug use, especially in the context of harsh government crackdowns on drug users, is not justified.

Interference with Harm Reduction Services

The Thai government has made numerous public commitments to develop and implement harm reduction programs on a national scale for people who use drugs, and specifically recognized their importance as an entry point for HIV treatment for drug users.[55] But the government has provided minimal support for harm reduction services for people who use drugs, notwithstanding their proven effectiveness, and in some cases government agents have directly interfered with them. In February 2004 the United Nations Office on Drugs and Crime estimated that barely 1 percent of injection drug users in Thailand were receiving harm reduction services.[56] A July 2006 study by USAID found no improvement, reporting that harm reduction reached 1 percent of injection drug users in Bangkok.[57]

The possession and sale of needles and syringes is legal in Thailand, and they can be purchased from a pharmacy without a prescription. However, under Thai law the possession of paraphernalia can be used as evidence to establish "the commission of an offense related to narcotics."[58] The National Police Office has issued a memorandum instructing that possession of injecting equipment is not grounds for arrest.[59] In practice, however, police regularly interfere with drug users' efforts to take

55 See, for example, UNGASS submission (2006) (recognizing effectiveness of harm reduction interventions, and recommending that Thailand act quickly to scale up outreach and related harm reduction programs) and Thailand Ministry of Public Health, "Towards Universal Access by 2010" (pledging to develop and implement "new approaches and initiatives to promote national adoption of harm reduction strategies").

56 UNODC-SEARO, "Drugs and HIV/AIDS in South East Asia, "p. 15.

57 USAID, "Mapping HIV/AIDS Service Provision for Most At-Risk and Vulnerable Populations in the Greater Mekong Sub-Region," July 2006, http://www.unaids.org.vn/facts/docs/MappingHIVAIDS.pdf (accessed September 25, 2007), pp. 46-47.

58 The Narcotics Act of B.E. 2522 (1979), section 14.

59Letter number Taw Chaw 0031212/1468 from Lieutenant General Chanwut Wacharapuk, acting deputy commander in chief, National Police Office, Februrary 27, 2006, in reference to letter number #0424.4/4/350 from Department of Disease Control, Ministry of Public Health, January 30, 2006.

measures to prevent HIV, including using the possession of sterile syringes or presence at a methadone clinic, as a basis for drug charges.

The police superintendent in Chiang Mai who acknowledged that his office maintained a blacklist of suspected drug users (see above) said that possession of clean needles, while legal, was a basis for questioning someone on the blacklist. The Office of the Narcotics Control Board confirmed that in practice even clean syringes would sometimes be taken by police officers as evidence of drug use.[60]

Government officials—including Ministry of Public Health representatives, physicians providing HIV/AIDS and drug treatment services, and law enforcement officials—said that syringe exchange was either illegal or impracticable in Thailand, notwithstanding international guidance to the contrary, and many government authorities see it as "immoral," "foreign," "not Thai, or not appropriate for Thailand," or "encouraging drug use." US government policy banning the use of US funding for syringe exchange services also undermines harm reduction work.[61] Peer outreach workers with US-funded organizations said that their employers instructed that syringe provision was prohibited by the terms of their organizations' agreements with USAID, which are governed by US law.[62] Though US-funding recipients could choose to use other funding for syringe exchange, outreach workers to drug users throughout Thailand said that their employers did not do so. Lek L., an outreach worker with a US-funded organization in Chiang Mai, said, "It's not [my employer's]

60 Human Rights Watch and TTAG interview with Pithaya Jinawat, Bangkok, July 25, 2006.

61 The Health Omnibus Programs Extension of 1988, Pub L No 100-607, 102 Stat 3048 (sec. 256(b)), imposed a federal ban on funding of needle exchange program services "unless the [Surgeon General] of the US determines that a demonstration needle exchange program would be effective in reducing drug abuse and the risk that the public will become infected with the etiologic agent for acquiring immune deficiency syndrome." Even more stringent language has been included in annual appropriations bills, which have stipulated without exception since 2000 that no funding could be spent "to carry out any program of distributing sterile needles for the hypodermic injection of any illegal drug or distributing bleach for the purpose of cleansing needles for such hypodermic injection," see Departments of Labor, Health and Human Services, and Education and Related Agencies Appropriations Act, 2006, Pub.L. 109-149, 119 Stat. 2833, 2879 (sec. 505), and the Ryan White Comprehensive AIDS Resources Emergency Act of 1990, Pub L No 101-381, 42 USC 300ff (sec. 422). The U.S. government has chosen to apply the restriction on financing for needles and syringes to funding for overseas programs See USAID, "Guidance On The Definition And Use Of The Child Survival And Health Programs Fund and the Global HIV/AIDS Initiative Account FY 2004 update," http://media.shs.net/globalaids/Field_Officer_Orientation_2004/Module2-SettingtheContext/DefChildSurvival-HealthPrograms2004.doc (accessed November 12, 2007).

62 In fact, US policy does not bar US-funding recipients from using non-US funds for syringe exchange.

policy to provide needles…. [My employer] gets USAID money, and USAID doesn't support needle exchange."[63]

Peer outreach workers promoting syringe exchange face harassment and abuse by police, who recognize them as drug users, and risk arrest for carrying syringes or suspected distribution. As Prem C., an outreach worker to drug users in Bangkok, explained, "We cannot provide needles because it is against the law. It is considered to be promotion. If we carry needles, we can be arrested and have our urine tested."[64]

Outreach workers also reported being targeted for police harassment at the Bangkok methadone clinic where they worked and facing repeated harassment and arrest, including having been arrested outside the methadone clinic two days before meeting with Human Rights Watch and TTAG. Prem said, "At the time [of the arrest], we had just had an outreach activity in the members' room at the clinic, and we were taking a lunch break, smoking outside the clinic."[65] Daeng P., an outreach worker with Prem C., told researchers, "I was in front of the clinic, near a public phone. The police said, 'Don't move! We've been looking for you.' Three or four police came; they were aware we are former drug users. They searched us in front of the clinic and made us lose face in front of our peers. They took six of us down to the police station, where we stayed for two hours. The police said if we didn't want to be arrested, we should help them find dealers."[66]

Obstacles to ART in Healthcare Settings

Denial of Antiretroviral Treatment to Drug Users

In 2004 Thailand amended national guidelines that had until then excluded active drug users from eligibility for antiretroviral treatment.[67] This policy change has

63 Human Rights Watch interview with Lek L., Chiang Mai, July 12, 2006.

64 Human Rights Watch and TTAG interview with Prem C. , Bangkok, December 2, 2006.

65 Ibid.

66 Human Rights watch interview with Daeng P., Bangkok, December 2, 2006.

67 The guidelines stated, "[P]atient who still has risk behaviors, such as drug addiction, should rehabilitate until rehabilitated first." Ministry of Public Health, Thailand, "Practical Approach to developing the service system and monitoring the results of treatment for people living with HIV/AIDS with ARV therapy in Thailand, 2002 (National ARV Treatment Guidelines)," November 2002, p. 16 (in Thai).

apparently benefited some drug users, who are now receiving ART under the government program.[68] But the government did not follow its policy change with awareness raising and training, and therefore many healthcare providers do not know or do not follow the revised guidelines. HIV clinicians variously reported that hospital policy was to deny drug users ART, notwithstanding what they knew to be government policy to the contrary, or contended that government policy excluded drug users from government ART programs and therefore drug users were not eligible for ART. In both circumstances the denial extended to drug users on methadone treatment (see below).

HIV clinicians in two of the provinces visited openly stated that they would not provide ART to active drug users. Dr. Somsak Wasuwithitkul, deputy director of a district hospital in Satun province, said that hospital policy was to exclude active drug users from antiretroviral treatment, despite government policy to the contrary. "It's not the Ministry of Public Health regulation, but if a patient is still using drugs, they will not start antiretroviral therapy."[69] A nurse at a provincial hospital in the south who provided HIV counseling for people living with HIV, including patients on ART, said that at her hospital, "We ensure that the patient has stopped using drugs, or the doctor won't provide antiretroviral treatment to them."[70] This nurse understood abstinence from methadone or drug use as a condition of eligibility under the national ART program. She said that "according to the [the government-funded program], a patient has to stop using drugs to be entitled to enroll in the program."[71]

Health care providers justified denial of ART to drug users based on concerns that drug users would not adhere to antiretroviral regimens, and that drug or methadone use would undermine the effectiveness of ART.[72]

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68 Human Rights Watch and TTAG interviewed 11 drug users on antiretroviral treatment and at least one drug user who was eligible for treatment and was not receiving it.

69 Human Rights Watch and TTAG interview with Dr. Somsak Wasuwithitkul, deputy director, Langhu hospital, July 8, 2006.

70 Human Rights Watch and TTAG interview with nurse (name withheld), Satun province, July 10, 2006.

71 Ibid.

72 See, for example, Human Rights Watch and TTAG interview, Satun province, July 10, 2006. Ibid.

Drug users throughout Thailand reported having been told that they could not get ART if they used drugs. The comments of Noi I., a Bangkok drug user, were typical. She told researchers, "I went to the doctor [at a Bangkok hospital] and said that I have HIV, how do I get treatment? He said that I have to give up drugs. The doctor is afraid that the medicine would go against the drugs. The social worker talked to me personally and said that the medicines would not work well if I was still on drugs. I never returned. I moved to a different health center. I never got ART, just drug treatment."[73]

Not surprisingly, drug users reported that they would not disclose drug use to an HIV clinician out of fear that they would be forced to leave the ART program (if they were receiving ART) or considered ineligible to receive ART. Thien C., age 44, a peer outreach worker in Bangkok who was on ART, said that he would not disclose his drug use to his doctor, "because I think I would get kicked out of the program."[74] Lek L., an outreach worker in Chiang Mai, said that alongside fear of being "blacklisted," a chief preoccupation among drug users was that physicians would refuse to provide them with treatment. "Most doctors require that people quit drugs before they get ART. Drug users may lie to the doctor if they have no record. Some can't get substitution [medication-assisted] therapy and some people die."[75]

Bias against drug users among PWA outreach workers

People living with HIV play an important role in facilitating access to antiretroviral therapy for their peers. This is particularly true for hospitals that are "comprehensive continuum of care" centers (CCCs), where people living with HIV/AIDS are included as part of the CCC team. In addition to providing adherence and other counseling to people living with HIV, they often function as gatekeepers to antiretroviral treatment by assisting HIV clinicians in identifying people living with HIV who might be in need of ART.

Outreach workers to drug users said that leaders of people living with HIV/AIDS groups were biased against drug users, whom they presumed were incapable of

73 Human Rights Watch and TTAG interview with Noi I., Bangkok, July 23, 2006.

74 Human Rights Watch and TTAG interview with Thien C., Bangkok, November 30, 2006.

75 Human Rights Watch Lek L., Chiang Mai, July 12, 2006.

responsibly taking ART, and that they blocked drug users from obtaining ART by refusing to refer them to physicians for treatment. An outreach worker to drug users in Samut Prakhan said that the leader of a hospital-based group of people living with HIV had refused to assist him in obtaining referrals to ART for drug users with AIDS, and had made plain that he did not think drug users deserved treatment.

> They think that if they only have one pill [limited ART], they would prefer to give it to a non-drug user, because a drug user won't take ART responsibly and will continue to get high.
>
> I was told this by a peer counselor to people with HIV… This is from one of the PWA leaders. This guy is in charge of giving counseling to people who test positive. He's a leading PWA with the new friends club. He is an employee of the CCC. He said this when [name withheld] was taken there and his CD4 was three.[76] I asked why he didn't give [name withheld] ART. He said he was going to die anyway; better to save the ART. Another friend who was seriously ill tried to get advice from this guy about why his friend was not referred to Bamrasnaradura hospital [in Nonthaburi province]. He said it doesn't matter where he's referred, because he will die anyway.[77]

Problematic Approaches to Methadone Patients

Methadone maintenance therapy has been shown to improve uptake and adherence to ART for HIV-positive opiate users.[78] Its integration into HIV/AIDS care and treatment programs has thus been recommended by international drug and health

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76 CD4+ T–lymphocytes (CD4+ T-cells) coordinate the body's immune response and are the primary targets of HIV. Destruction of CD4 T-cells is the main cause of the progressive weakening of the immune system in HIV infection. Lower numbers of circulating CD4+ T-cells imply more advanced HIV disease and less competent defense mechanisms. WHO and UNAIDS, "CD4+ T-Cell Enumeration Technologies. Technical Information," 2007, http://www.who.int/diagnostics_laboratory/CD4_Technical_Advice_ENG.pdf (accessed November 15, 2007), p. 1.

77 Human Rights Watch and TTAG interview with Muu T., Samut Prakhan, December 2, 2006.

78 See WHO, UNODC, UNAIDS, "Substitution maintenance therapy in the management of opioid dependence and HIV/AIDS prevention: Position paper," p. 2; Thomas Kerr et al., "Opioid Substitution and HIV/AIDS Treatment and Prevention," The Lancet, vol. 364 (November 27, 2004), pp. 1918-19.

organizations.[79] Coordination between methadone and HIV/AIDS treatment programs is critical because interactions between antiretroviral drugs and methadone (as well as other drugs) have a range of consequences for people using antiretroviral drugs together with other drugs. This includes the need for increases in methadone when given, for example, with certain common first- and second-line HIV therapies provided in Thailand, such as nevirapine, efavirenz, nelfinavir, and lopinavir.[80] Both efavirenz and nevirapine interact with methadone, decreasing concentrations of methadone, and causing withdrawal symptoms (interactions with heroin and other opiates are similar). The WHO notes that methadone withdrawal is common, and that "significant methadone dose increase" is usually necessary for patients receiving efavirenz or nevirapine.[81]

Thailand has no national policy or guidance on providing ART to methadone patients, nor on coordinating drug dependence treatment with HIV treatment and care. As a result, practice varies among provinces. Some healthcare providers either refused to treat methadone patients, or they admitted drug users to ART programs without inquiring about their methadone use and thus depriving them of essential health information and compromising their medical care. The denial of ART based on methadone use is contrary to international health standards and inconsistent with obligations under the right to health. The failure to coordinate methadone and ART treatment compromises patient access to information and to medically and scientifically appropriate care.

Denial of ART treatment to methadone patients

The Bangkok Metropolitan Administration (BMA) policy is to integrate methadone with HIV treatment.[82] As of the end of 2006, the BMA provided methadone at 19 sites

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79 WHO, UNODC, UNAIDS, "Substitution maintenance therapy in the management of opioid dependence and HIV/AIDS prevention: Position paper," p. 2.

80 The majority of people receiving ART through the public health system are on a fixed-dose combination of stavudine, lamivudine, and nevirapine that is produced and sold by the Government Pharmaceutical Office (GPO) as GPO-vir. Patients who cannot tolerate nevirapine may receive a regimen substituting efavirenz or indinavir/retonavir for nevirapine. World Bank, The Economics of Effective AIDS Treatment (Washington, D.C.: The World Bank, 2006), p. 62.

81 WHO Regional Office for Europe, "HIV/AIDS Treatment and Care for Injecting Drug Users," p. 25.

82 Human Rights Watch and TTAG interview with Dr. Sitthisat Chiamwongpaet, director general, Health Department, Bangkok Metropolitan Administration, Bangkok, December 4, 2006.

(17 clinics and 2 hospitals) to 2,000 patients.[83] Dr. Sitthisat Chiamwongpaet, director general of the BMA's health department, said that BMA clinics and hospitals coordinated methadone, ART, and TB services. Dr. Chiamwongpaet estimated that there were 600 to 700 people on ART and methadone in Bangkok at the end of 2006. When asked whether the BMA required people to stop methadone as a condition of receiving ART, Dr. Chiamwongpaet replied, "No. I think that methadone is attractive to induce treatment. If you don't have methadone, they don't come to see you."[84]

However, drug users in Bangkok reported that, in practice, ART and methadone treatment were not always coordinated. Thien C., the peer outreach worker in Bangkok who is on ART, acknowledged that staff at methadone clinics were well situated to provide information and facilitate access to ART for drug users, but said that in his experience some Bangkok health care workers refused to provide ART to methadone patients. Thien used to get methadone at a Bangkok clinic that also provided ART. But after hearing staff members chastise drug users on methadone and state publicly that they would not provide them with ART because it would be "a waste of medicine," Thien stopped getting methadone there. Thien said that when he used methadone he bought it privately.[85]

Moreover, the Bangkok Metropolitan Administration's policy appears to be the exception. Dr. Sittichai Kulpornsirikul, an HIV clinician in nearby Samut Prakhan province, said that Samut Prakhan provincial hospital policy was to require that patients quit methadone before they would provide them with ART.[86] Human Rights Watch and TTAG noted that there was a methadone clinic at the hospital, which would have enabled HIV clinicians and methadone providers to coordinate drug treatment and ART for patients who needed both services, were they so inclined. As a practical matter, they did not coordinate patient care. Dr. Kulpornsirikul acknowledged, "Usually smart patients don't come here to take methadone. We have their case portfolio, so the hospital can monitor this…. Drugs are treated

83 BMA operated 19 narcotic clinics in Bangkok, including two based in hospitals. Human Rights Watch and TTAG interview with Dr. Chiamwongpaet, December 4, 2006.

84 Human Rights Watch and TTAG interview with Thien C., Bangkok, November 30, 2006.

85 Ibid.

86 Human Rights Watch and TTAG interview with Dr. SIttichai Kulpornsirikul, Samut Prakhan hospital, December 4, 2006.

elsewhere. They don't tell us directly if they take methadone. If they take methadone here at Samut Prakhan hospital, we would know."[87]

A methadone provider at a public hospital in Satun province that also provided ART named two factors contributing to the steep decline of patients at her methadone clinic (from 43 to 3 since 2002): the government's recent crackdown on drug users and the requirement that patients stop methadone as a condition of taking ART. "[We have so few patients]" because this year [2006] the government announced a drug war," she said. In her seven years at the methadone clinic, she "never had a patient on antiretroviral therapy and methadone, because patients are not allowed to have both. They have to choose one."[88]

Clinicians' failure to coordinate ART and methadone use

Dr. Somsak Wasuwithitkul, deputy director at Langhu hospital in Satun province (which had an on-site methadone clinic), reported what amounts to a policy of willful ignorance at his hospital about ART patients' drug or methadone use: "The hospital doesn't get information about current drug use. Even old cases used to get ART and go home and use drugs and go elsewhere for methadone…. But if they are on ART and start using drugs, they find methadone elsewhere. The methadone clinic informs me and it alarms me because I didn't have this information before."[89] Several other HIV clinicians reported a "don't ask, don't tell" policy toward drug users, refusing to inquire about patients' drug use or drug treatment history, in some cases despite knowledge or suspicion of current drug use or methadone treatment. The comments of a doctor providing ART at a major hospital in Chiang Mai were typical of responses by many providers interviewed: "Most of the people I'm treating here—I don't know if someone is a drug user or not. I don't ask about drug use history, whether they use or not, how they got HIV. I don't want to interfere with their personal rights. Mostly I don't ask about HIV transmission route. I don't ask about a patient's methadone use.[90]

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87 Ibid.

88 Human Rights Watch and TTAG interview with methadone provider (name withheld), Langhu hospital, Langhu, July 8, 2006.

89 Human Rights Watch and TTAG interview with Dr. Somsak Wasuwithitkul, deputy director, Langhu Hospital, Langhu, July 8, 2006.

90 Human Rights Watch and TTAG interview with Dr. Virat Klinbuayaem, Sanpathong Hospital, July 14, 2006.

Dr. Sittichai Kulpornsirikul, the primary HIV doctor in Samut Prakhan hospital, and Bang-orn Jaemrukjaeng, a nurse who worked in HIV care at the hospital, said they did not inquire about patients' drug use nor were patients likely to disclose this information. They also denied ART, as a matter of policy, to patients on methadone (as noted above). Both acknowledged, however, that some of their patients may have been using drugs or taking methadone. The nurse recalled that they had had two patients on ART who had been on methadone. "They said they quit. Actually, we can't know for sure. We don't know, we can't follow them around."[91] Similarly, a methadone provider at Samut Prakhan hospital told Human Rights Watch and TTAG, "Yes, there are ART takers on methadone... The methadone provider won't know—unless the user tells us they are on ART, we don't investigate."[92]

This kind of failure to coordinate HIV/AIDS and drug treatment services may be undermining both HIV/AIDS care for drug users, and drug treatment for people living with HIV/AIDS. Given that drug treatment services are often provided at or near hospitals and clinics that provide HIV/AIDS services, the failure to ensure such coordination represents a missed opportunity to ensure access to healthcare services as well as lifesaving information to drug users living with or at risk of HIV/AIDS.

Lack of Knowledge on Drug-Drug Interactions

As noted above, interactions with antiretroviral drugs have a range of consequences for people using them together with methadone or other drugs. Several HIV clinicians we spoke to acknowledged that they lacked sufficient information about drug-drug interactions, and said that they would like more training on this issue.[93]

Similarly, several drug users said that they would like more information about ART and drug use, but that they were afraid that they would be denied ART if they

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91 Human Rights Watch and TTAG interview with Bang-orn Jaemrukjaeng, nurse, Samut Prakhan, December 4, 2006.

92 Human Rights Watch and TTAG interview with Jutatip Hemin, head of psychological counseling, Samut Prakhan hospital drug treatment clinic, Samut Prakhan, December 4, 2006.

93 See, for example, Human Rights Watch and TTAG interview with Dr. SIttichai Kulpornsirikul, Samut Prakhan hospital, Samut Prakhan, December 4, 2006; Human Rights Watch and TTAG interview with Dr. Somsak Wasuwithitkul, deputy director, Langhu hospital, Satun province, July 8, 2006; Human Rights Watch and TTAG interview with Dr. Praphan Phanuphak, Bangkok, July 20, 2006.

disclosed their drug use. As a result, drug users on ART are forced to conduct what essentially amount to daily, individual experiments on themselves, with dangerous potential consequences for their health and, ultimately, their lives.

Bang In T., a 40-year-old injection drug-user on ART, told us that he occasionally injected amphetamines. Since starting ART, he sometimes had difficulty breathing. He said that he would like to know more about drug use, HIV, and ART, but was afraid to speak with his doctor, who had said that he would stop providing ART to anyone who used drugs. "I feel uncomfortable speaking with the doctor about drug use. I'm afraid the doctor wouldn't give me ART and wouldn't take care of me. The doctor hasn't told me that directly, but he has said that if he knows if anyone uses drugs, he would stop providing ART to them. I would feel really good if I could speak with the doctor about occasional drug use and not worry about losing ART. I have not received information about the relationship between drug use, HIV, and ART. I assume there's a bad interaction, but I would like to know. I don't know where I would get this information."[94]

Some drug users reported receiving limited information about methadone and ART interactions from their peers. However, apart from the warning that taking antiretrovirals with drugs could be lethal, none of the drug users interviewed reported receiving any information about either methadone or illicit drug use and ART from healthcare providers.

When asked whether he had been told anything about the effect of methadone on ART, Thien C., an HIV-positive methadone patient on ART, replied, "I went to the harm reduction group. They said that some antiretrovirals can't be used with methadone because they make methadone less effective." But Thien had never received information about methadone/ARV interactions from his healthcare providers. He said, "I have never gotten any information from a doctor or nurse about the effect of methadone on ARV."[95] Mee U., 33, said that he had been told by a doctor, "If you are on ART, you have to stop using drugs because if you take ART with drugs, you could

94 Human Rights Watch and TTAG interview with Bang In T., Langhu, July 9, 2006.

95 Human Rights Watch and TTAG interview with Thien C., Bangkok, November 30, 2006.

die. I believe this is true, because I know the situation of someone who was on ART [who died] and his friend said that he used drugs heavily."[96]

Inadequate Voluntary Counseling and Testing Services

Drug users living with HIV need to know their HIV status in order to seek antiretroviral treatment and other health services. Voluntary HIV testing and counseling (VCT) is the process by which an individual undergoes confidential counseling to enable an informed choice to be made about whether to take an HIV test and learn one's HIV status. The voluntary nature of VCT is critical to ensure that HIV testing is not coerced, and that an individual has made an informed choice about whether or not to take an HIV test.

VCT is essential to identify drug users living with HIV and AIDS for prompt entry into HIV care and support services, as well as referral to drug treatment and other health and social services for those testing positive for HIV. VCT also provides an important opportunity to counsel drug users about harm reduction. It has proved effective in reducing HIV risk behaviors among drug users, and is therefore an integral part of HIV prevention strategies for drug users.[97] A recent review in Thailand showed that injection drug users who were already confirmed to be HIV-positive had a better understanding of HIV prevention than injection drug users who were unaware of their status (97-100 percent HIV-positive compared with 48–70 percent HIV-unknown status knew sharing needles could transmit HIV infection).[98]

HIV voluntary testing and counseling has been available in government hospitals since 1992. Thailand's Ministry of Public Health and international organizations have found, however, that VCT services in hospitals are constrained by inadequate staff training and staff shortages, lack of confidentiality, the cost of VCT, and the lack of

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96 Human Rights Watch and TTAG interview with Mee U., Samut Prakhan, December 2006.

97 See, for example, H. Colon et al., "Behavioral effects of receiving HIV test results among injecting drug users in Puerto Rico," AIDS (1996), vol. 10, pp. 1163-68; D. Gibson et al., "Effectiveness of brief counseling in reducing HIV risk behavior in injecting drug users: final results of randomized trails of counseling with and without HIV testing," AIDS and Behavior (1999), vol. 3, pp. 3-12; R. MacGowan et al., "Sex, drugs and HIV counseling and testing: a prospective study of behavior-change among methadone maintenance clients in New England, AIDS (1997), vol. 11, pp. 229-235.

98 U. Perngparn and Petchsri Sirinirund, Department of Disease Control/Ministry of Public Health, Thailand, and UNDP, "Mid-term Review on National Plan for the Prevention and Alleviation of HIV/AIDS in Thailand 2002-2006: Drug Dependents," p. 7.

anonymous testing.[99] The Ministry of Public Health and the World Health Organization have also observed that little has been done to address the specific challenge of providing VCT services to drug users, notwithstanding sustained high HIV prevalence rates among them.[100] A 2006 study by Thai researchers concerning VCT to drug users found that counseling is either not provided or ineffective, and that new HIV infections among drug users remain high, despite having had VCT.[101]

Human Rights Watch and TTAG interviews revealed a number of problems with VCT services to drug users. Drug users reported that they had been tested for HIV without their informed consent at drug treatment clinics or while in prison; that they had received little (if any) HIV-related information or counseling prior to the test (including that they were being tested for HIV), and little or no post-test counseling; and that they received no referral to medical or social services if they tested positive, or on HIV prevention specific to drug use.

The administration of inadequate pre- and post-HIV test counseling constitutes a severe limitation on the human right to receive essential information on health. It also compromises opportunities to link drug users living with HIV to adequate care and treatment services, impeding the states' fulfillment of its positive obligation under the right to health to take steps necessary for the "prevention, treatment and control of epidemic … diseases." The United Nations International Guidelines on HIV/AIDS and Human Rights (UN Guidelines), which provide guidance in interpreting international legal norms as they relate to HIV and AIDS, has advised that "public health legislation should ensure, whenever possible, that pre- and post-test counseling be provided in all cases" because counseling ensures the voluntary nature of HIV testing and contributes to the effectiveness of subsequent care or HIV prevention. [102] The research of Human Rights Watch and TTAG indicates that

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99 Ministry of Public Health, Thailand and WHO-SEARO, External Review of the Health Sector Response to HIV/AIDS in Thailand, p. 35; UNDP, Thailand's Response to HIV/AIDS: Progress and Challenges, pp. 40-41.

100 Ministry of Public Health and WHO-SEARO, External Review of the Health Sector Response to HIV/AIDS in Thailand, pp. 26-27.

101 Surinda Kawichai et al., "HIV voluntary counseling and testing and HIV incidence in male injecting drug users in Northern Thailand," Journal of Acquired Immune Deficiency Syndrome, vol. 41, no. 2, February 1, 2006, pp. 186-193 (estimating 10.2 HIV incidence rate among drug users who had been tested for HIV , and finding that 59 percent of those tested had received no pre- or post-test counseling).

102 Office of the United Nations High Commissioner for Human Rights and the Joint United Nations Programme

counseling provided to people who use drugs in the public health system is insufficient on both counts: it fails to equip people who use drugs with the information necessary for them to give informed consent to testing, and fails to give them the information they need to pursue HIV care or treatment.

Pong H., age 29, was tested for HIV in Samut Prakhan. He told researchers, "My [pre-test] counseling was: 'If you have HIV, will you be able to accept it?...There was no discussion. The official just asked, 'Is there any possibility that you might have HIV?'"[103]

Staff and patients at outpatient drug treatment clinics reported that HIV tests were administered on a regular basis to methadone patients.[104] Drug users reported that they felt coerced into taking an HIV test as a condition of receiving methadone or participating in a clinical trial. Wat V., age 31, found out that he was HIV-positive at a methadone clinic where he was an outpatient. He told researchers, "The nurse at the clinic said that they wanted to test everyone, and they did it." When asked if he had been given any information about the test, Wat replied, "No. That's why I didn't know what the blood test was for. It was like they forced me to do it. I was taking methadone with them [the clinic], so I had to cooperate. They didn't say it was an HIV test. They just said it was a blood sample test, but they didn't say what it was for. I thought it might be HIV but they didn't explain. They just said, 'Today before you take methadone, you have to take a test.'"[105]

Healthcare providers have an important opportunity to provide counseling as well as referral to appropriate care, treatment, and prevention services when individuals return for test results. But healthcare providers failed to take advantage of this

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on HIV/AIDS, HIV/AIDS and Human Rights International Guidelines , 1998, HR/PUB/98/1, Geneva: UNAIDS, para. 20(c).

103 Human Rights Watch and TTAG interview with Pong H., Bangkok, December 12, 2006.

104 Human Rights Watch and TTAG interview with Wat V., Bangkok, December 1, 2006; Human Rights Watch and TTAG interview with Chuai C., Samut Prakhan, December 2, 2006; Human Rights Watch and TTAG interview with Mee U., Samut Prakhan, December 2, 2006; Human Rights Watch and TTAG interview with Jutatip Hemin, head of psychological counseling, Samut Prakhan hospital drug treatment clinic, December 4, 2006; Human Rights Watch interview with social worker, Lad Phrao Clinic, December 8, 2006.

105 Human Rights Watch and TTAG interview with Wat V., Bangkok, December 1, 2006; see also Human Rights and TTAG interview with Chuai C., Samut Prakhan, December 2, 2006; Human Rights and TTAG interview with Karn U., Samut Prakhan, December 2, 2006; Human Rights Watch and TTAG interview with Pong H. , Bangkok, December 12, 2006.

opportunity when reporting HIV test results to drug users. When asked how he was informed of his test results, Pong H. said, "The officer just said you are positive. He didn't tell me the difference between HIV and AIDS. There was no information about how to take care of yourself. They just said, "You're positive.""[106] When Wat V. returned for his test results, the social worker told him "You have to be able to bear with it. Can you take it?'" When he said yes, she called him and told him, "You have HIV, and you have to look after your health. But it's not at the level where you have to take drugs. You also have hepatitis C."[107]

Hepatitis C

Hepatitis C virus (HCV) is endemic among injection drug users in Thailand. Government health officials were forced to acknowledge the HCV epidemic after a series of studies reported that HCV prevalence among Thai injection drug users was greater than 90 percent.[108] Due to overlapping modes of transmission, HCV is highly prevalent among HIV-positive injection drug users. Studies by Thai researchers have found extremely high HIV/HCV co-infection prevalence among injection drug users, including coinfection levels as high as 99 percent among injection drug users in prison. [109]

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106 Human Rights Watch and TTAG interview with Pong H., Samut Prakhan, December 12, 2006.

107 Human Rights Watch and TTAG interview with Wat V., Bangkok, December 1, 2006.

108 Human Rights Watch and TTAG interview with Aumphunporn Buavirat, psychologist, Health Department, Bangkok Metropolitan Administration, December 8, 2006 (citing unpublished World Health Organization study reporting 96 percent HCV prevalence among Bangkok injection drug users); T. Hansurabhanon et al., "Infection with hepatitis C virus among intravenous drug users: prevalence, genotypes, and risk-factor-associated behavior patterns in Thailand," Annals of Tropical Medicine & Parasitology, vol. 96, no. 6, (2002) pp. 615 – 625 (92.5 percent hepatitis C prevalence among injection drug users in southern Thailand); J. Jittiwutikarn et al., "Hepatitis C Infection among Drug Users in Northern Thailand," American Journal of Tropical Medicine and Hygiene, vol. 74, no. 6 (2006), pp. 1111-1116 (86 percent hepatitis C prevalence among injection drug users).

109 W. Paungtubtim et al., "High Incidence and Prevalence of Hepatitis C Virus Infection among Bangkok Inmates, Thailand," presented at XVth International AIDS Conference; Bangkok, 2004. See also Somnuek Sungkanupharp et al., "Prevalence of Hepatitis B Virus and Hepatitis C Virus Co-infection with Human Immuno-deficiency Virus in Thai Patients: a Tertiary-care-based Study," Journal of the Medical Association of Thailand, vol. 87, no. 11 (2004) (88 percent of HIV-positive injectors co-infected with hepatitis C).

Hepatitis C co-infection is a significant co-morbidity for HIV-positive people, because:

- HIV accelerates HCV disease progression.
- HIV infection doubles the risk of developing cirrhosis.
- Hepatitis C co-infection complicates HIV treatment, by increasing the risk for antiretroviral-associated liver toxicity and treatment discontinuation.
- In the United States and parts of Europe where ART is available, HCV-related end-stage liver disease has become a leading cause of death among HIV-positive people.

HIV treatment is especially important for co-infected persons. ART may delay hepatitis C progression and decrease liver-related mortality in co-infected persons, but HIV drugs must be selected carefully, since some—including those provided in Thailand through the government treatment program—are particularly liver-toxic.[110]

Hepatitis C is treatable regardless of HIV status. Indeed, the strain of hepatitis C common in Thailand (genotype three) has one of the best prospects for successful treatment.[111] HCV can be eradicated in approximately 50 percent of mono-infected persons, and up to 44 percent of co-infected individuals. HCV treatment has additional benefits, even for non-responders: it has been associated with decreased liver inflammation and a lower risk of liver-related mortality.[112]

Given the prevalence of hepatitis C among Thai injection drug users, it is astonishing that many drug users have little or no information about hepatitis C transmission, prevention, natural history, or treatment. Healthcare workers and service providers—including HIV clinicians and drug treatment providers—also lack this crucial information.

HCV is preventable if drug users are given the knowledge and the means to protect themselves and each other. There is ample opportunity to prevent new HCV

110 The risk for serious liver disease is greatest in people with less than 200 CD4 cells/mL.

111 The success rate for treatment for genotype three is up to 82 percent, and up to 73 percent for people co-infected with HIV.

112 Raymond T. Chung et al., "Peginterferon Alfa-2a lus Ribavirin versus Interferon alfa-2a plus Ribavirin for Chronic Hepatitis C in HIV-coinfected persons, New England Journal of Medicine, vol. 351,no. 5 (July 29, 2004), pp. 451-9; MW Fried et al., "Peginterferon Alfa-2a plus Ribavirin for Chronic Hepatitis C Virus Infection. New England Journal of Medicine, vol. 347,no. 13 (Sept. 26, 2002), pp. 975-82; Montserrat Laguno et al., Peginterferon Alfa-2b plus Ribavirin Compared with Interferon alfa-2b plus Ribavirin for Treatment of HIV/HCV Co-infected Patients, AIDS, vol. 18, no. 13 (Sept. 2004), pp. 27- 36.

infections among Thai injectors since most become infected with hepatitis C within two to three years of initiating drug use.[113] Unfortunately, there is no organized hepatitis C prevention program in Thailand. The majority of Thailand's injection drug users are unaware of their HCV status and cannot get tested or treated. Neung P., 47, a longtime peer educator, ran a drug treatment center for 22 years where he worked with scores of injection drug users. He told researchers,

> There's almost no information about hepatitis. If it's HIV, they know. But almost no doctors have information about hepatitis C. If I hadn't come into contact with the Thai Drug Users Network, I wouldn't know about hepatitis C. [114]

In Thailand, hepatitis C treatment costs well over US$10,000 per person and is therefore unattainable for most drug users. The government does not provide a comprehensive care package; diagnostics and monitoring, such as hepatitis C viral load and liver enzyme testing are not available to persons who cannot afford them. Neung P. told researchers, "I went to a private hospital and said, 'I've got hepatitis C and I want to be treated.' [The doctor] said, 'That's impossible. It's nearly impossible to find hepatitis C treatment in Thailand.'"[115]

Hepatitis C treatment is available in Thailand, however. The major barrier is its prohibitive cost. According to Dr. Anchalee Avihingsanon, an HIV clinician in Bangkok, "99 percent of people with hepatitis C can't get treatment. You can only get treatment if you have the money."[116] Dr. John Lewitworapong, director of medical services at Klong Prem Central Prison explained, "We don't check for hepatitis C because it's expensive."[117]

The lack of information about hepatitis C and hepatitis C/HIV co-infection keeps drug users from getting appropriate treatment for both conditions. Thien C., who is co-

113 T. Hansurabhanon et al.,"Infection with hepatitis C virus among intravenous-drug users: prevalence, genotypes and risk-factor-associated behaviour patterns in Thailand," pp. 615-625.

114 Human Rights Watch and TTAG interview with Neung P., Bangkok, July 21, 2006.

115 Ibid.

116 Human Rights Watch interview with Dr. Anchalee Avihingsanon, Bangkok, July 20, 2006.

117 Human Rights Watch and TTAG interview with Dr. John Lewitworapong, Bangkok, July 21, 2006.

infected, did not start antiretroviral therapy until more than a year after learning that his CD4 count had dropped to less than 200 cells/mL , when he therefore qualified clinically for ART, thus putting him at needless risk in the meantime for opportunistic infections and serious liver damage. Although Thien's physicians knew that he had been an injection drug user, he never received any information about hepatitis C from them. After learning from his peers that he was at risk for hepatitis C, he got tested and diagnosed with HCV. He had to switch hospitals twice before he was he able to enroll in an ART program. Thien told researchers that after learning that his CD4 count was less than 200, "I asked when I would get ART… I kept asking them because I knew the CD4 criteria. This was in 2004. They told me to take care of my liver first…. I was not given any treatment for my liver. They asked me how I got HIV. I told the doctor it was from drugs. [The doctor] said your liver is not good. . . It was about a year before I got ART."[118]

Access to HIV-related Services in Custodial Settings

Many Thai drug users are incarcerated at some point in their lives, including in prisons, remand or pretrial centers, juvenile detention centers, and compulsory drug treatment centers.[119] Incarceration, in turn, is strongly associated with HIV infection for Thai drug users.[120] Official statistics reported 869 known cases of HIV/AIDS and 331 deaths from AIDS-related causes in Thai prisons in 2004 (within a prison population of 167,000) [121], but in 2006 the Ministry of Public Health estimated actual

118 Human Rights Watch and TTAG interview with Thien C., Bangkok, November 30, 2006.

119 See C. Beyrer et al., "Drug Use, Increasing Incarceration Rates, and Prison-Associated HIV Risks in Thailand," AIDS and Behavior, vol. 7, no. 2, June 2003, pp. 153-161 (27 percent of drug users, and 60 percent of injection drug users, in Chiang Mai cohort had been incarcerated in their lifetime); K. Dolan et al., "Review of injecting drug users and HIV infection in prisons in developing and transitional countries," UN Reference Group on HIV/AIDS Prevention and Care among Injecting Drug Users, 2004; UNODC, "HIV/AIDS in Custodial Settings in South East Asia. An Exploratory Review into the Issue of HIV/AIDS and Custodial Settings in Cambodia, China, Lao, PDR, Myanmar, Thailand and Viet Nam," November 2006, p. 47; K. Choopanya et al., "Incarceration and Risk for HIV Infection Among Drug Users in Bangkok," Journal of Acquired Immune Deficiency Syndromes, vol. 29, no. 1, January 2002, pp. 86-94.

120 See, for example, Beyrer et al., "Drug Use, Increasing Incarceration Rates, and Prison-Associated HIV Risks in Thailand;" Dolan et al., "HIV in prison in low-income and middle-income countries," The Lancet Infectious Diseases, vol. 7, January 2007, pp. 32-41; H. Thaisri et al., "HIV Infection and risk factors among Bangkok prisoners, Thailand: a prospective cohort study," BMC Infectious Diseases, vol. 3, 2003; UNDOC , "HIV/AIDS in Custodial Settings in South East Asia," p. 57 (citing 2006 FHI study documenting high-risk behavior in four Bangkok prisons in 2005).

121 UNODC , "HIV/AIDS in Custodial Settings in South East Asia," p. 13.

numbers at about 4,800 cases (within a prison population of 160,000).[122] Data from studies in Thai prisons and among injection drug users who had been in pre- or post-trial detention suggest that the actual numbers may be much higher. Studies by Thai researchers have documented HIV prevalence rates as high as 40 percent among injectors who had been jailed, and documented significant risks of HIV infection related to syringe sharing both in pretrial detention and in prison.[123] The high rates of incarceration for drug-related offenses—more than 90,000 people in 2006—coupled with high HIV prevalence rates among drug users (especially among injection drug users) suggest that HIV/AIDS cases in prison may well exceed 4800.[124] People in custody also face a risk of exposure to other infectious diseases such as tuberculosis and Hepatitis C, which exacerbate HIV-infection and complicate medical treatment.[125]

Until mid-2007 Thailand had no clear national policy on providing ART in pretrial detention facilities and prisons.[126] Inmates who do receive antiretroviral treatment in

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122 Erika Fry, "AIDS Lingers Behind Bars," Bangkok Post, October 30, 2006 (noting 2006 announcement by Department of Corrections of 740 HIV/AIDS cases in prison, and Bureau of AIDS, TB, and STIs estimate of 4,800 HIV/AIDS cases in prison).

123 See, for example, Thaisri et al., "HIV infection and risk factors among Bangkok prisoners," BMC Infectious Diseases (finding 25.4 percent HIV prevalence among 689 inmates who agreed to be tested, 49 percent of whom injected during incarceration, and 95 percent of whom had shared injection equipment, and concluding that main HIV risk factors for Bangkok prisoners were those related to injection); Beyrer et al., "Drug use, increasing incarceration rates, and prison-associated HIV risks in Thailand," AIDS and Behavior, pp. 153-161 (38.2 percent of 104 male injection drug users who had been jailed were HIV-positive, compared to 20.2 percent who had not been jailed); A. Buavirat et al., "Risk of prevalent HIV infection associated with incarceration among injecting drug users in Bangkok, Thailand: Case-control study," British Medical Journal, vol. 326, 2003, pp. 308-326 (concluding that "IDUs in Bangkok are at significantly increased risk of HIV infection through sharing needles with multiple partners while in holding cells before incarceration"); Choopanya et al., "Incarceration and Risk for HIV Infection Among Drug Users in Bangkok," Journal of Acquired Immune Deficiency Syndromes, pp. 86-94.

124 According to the Department of Corrections' website, nearly 60 percent of prisoners (more than 90,000 people) were incarcerated for "offenses against narcotics law" in 2006, http://www.correct.go.th/eng/stat/statistic.htm#_Prison_Population_breakdown_by%20Type_1 (accessed November 12, 2007). Thai authorities have also estimated that 60 to 80 percent of prison inmates have some drug use history and reported that 22 percent were specifically incarcerated for drug misuse. UNDOC , "HIV/AIDS in Custodial Settings in South East Asia," p. 14.

125 TB prevalence in prisons is several times that in the general population. See, for example, S. Nateniyom, "Implementation of the DOTS Strategy in Prisons at Provincial Level, Thailand," International Journal of Tuberculosis and Lung Disease, vol. 8, no. 7, 2004, pp. 848-854. There is evidence that multidrug resistant TB rates may also be significantly higher among prisoners. See Public Health Watch, TB Policy in Thailand, (New York: Open Society Institute) p. 51 (citing studies). Thailand has reported TB and AIDS as the main causes of death in prison. See UNODC, "HIV/AIDS in Custodial Settings in South East Asia," p. 16.

126 Human Rights Watch and TTAG internview with Nipa Ngamtrairai, Bangkok, December 12, 2006. The new national AIDS plan, released in mid-2007, instructs the Ministry of Justice to ensure comprehensive HIV care and treatment to all prisoners, even if it requires that they leave the premises of the prison or jail for such treatment. National Committee for Prevention and

prison faced barriers to continuing care on release. Methadone (available in the community) or other medication-assisted treatment for opioid dependence are not provided in prison.

Access to Antiretroviral Therapy

HIV testing in prison is done at the prisoner's request, and antiretroviral treatment provided according to the same clinical guidelines as outside prison.[127] Dr. John Lewitworapong, director of medical services at Klong Prem Central Prison, said that there were "no barriers to HIV treatment in prison," as antiretroviral treatment was available free of charge to all Bangkok prisoners and prison officials made an effort to provide information about antiretroviral treatment and other HIV-related services to prisoners.[128] Dr. Lewitworrapong conceded, however, that prison officials were not reaching all prisoners in need of care, as some HIV-positive inmates did not want to disclose their status or submit to a test that would reveal their status.[129] Nipa Ngamtrairai, a public health officer with the Department of Corrections specializing in HIV/AIDS, confirmed that "very few [prisoners] ask for an HIV test."[130] As a result, prisoners may be identified as in need of antiretroviral therapy only after presenting with signs and symptoms of the disease.

An estimated 300 prisoners were receiving antiretroviral therapy nationwide in 2006, approximately 200 of whom were in Bangkok prisons.[131] Outside Bangkok, access to antiretroviral therapy depends on arrangements made with local Ministry of Public

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Solutions to AIDS Problems,"National Strategic Plan to Integrate Prevention and Solutions to AIDS Problems (2007-2011): Main Content (Book 1)," 2007, p. 15.

127 Human Rights Watch and TTAG interview with Nipa Ngamtrairai, Bangkok, December 12, 2006.

128 Human Rights Watch and TTAG interview with Dr. John Lewitworapong, director, medical services, Klong Prem Central Prison, Bangkok, July 21, 2006.

129 Ibid.

130 Human Rights Watch and TTAG interview with Nipa Ngamtrairai, December 12, 2006.

131 Ibid.; Human Rights Watch and TTAG interview with Dr. John Lewitworapong, July 21, 2006 (182 prisoners on ART in Klong Prem). Since 2003, Médicins Sans Frontières-Belgium/Thailand (MSF) has provided clinical services in two Bangkok prisons, and in June 2007 reported that it had enrolled 88 patients on antiretrovirals, including 63 who were still incarcerated. D. Wilson et al., "HIV Prevention, Care, and Treatment in Two Prisons in Thailand," PLoS Med., vol. 4, no. 6, June 2007. Note that prisoners' eligibility for ART is determined by the same criteria as for those outside prison. Many prisoners are thus ineligible for treatment because they cannot obtain Thai identity cards, such as foreign migrants and non-registered hill tribe people. Human Rights Watch telephone interview with Paul Cawthorne, head of mission, MSF, Bangkok, July 31, 2007.

Health officials and local provincial hospitals or with prisoners' family members.[132] According to Nipa Ngamtrairai, the government of Thailand had no clear national policy on providing antiretroviral therapy in prison and prisoners' access to antiretroviral therapy therefore "really depends on the local situation."[133] Ngamtrairai noted that "some hospitals are very strict," and therefore required prisoners to come to the hospital for treatment, which presented a significant burden for prison staff as well as a challenge to ensuring appropriate health care to prisoners: "You need two guards per person and so in Chiang Rai prison where 30 prisoners are on ART, it is impossible from a personnel standpoint to provide that service. You can't take a lot of people at once to the hospital."[134] In some provinces, healthcare workers are charged with providing HIV-related services in prison. According to Ngamtrairai, this situation also presented problems with access to care, not least because in some provinces a single doctor was charged with healthcare provision for several prisons or detention centers.

Nongovernmental organizations play an important role in providing HIV/AIDS-related services to prisoners, a fact that both international organizations and government officials have acknowledged.[135] Since 2003, Médicins Sans Frontières-Belgium/Thailand (MSF) has been providing HIV/AIDS services in two Bangkok prisons, and as of June 2007 had enrolled 88 patients in antiretroviral therapy.[136] Jai W., age 24, received antiretroviral therapy as well as medical treatment from MSF both while she was in prison and after release, until she was successfully transferred to the public health system.[137]

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132 Human Rights Watch and TTAG interview with Nipa Ngamtrairai, Bangkok, December 12, 2006; Human Rights Watch and TTAG interview with Dr. Tasana Leusaree, HIV/AIDS program manager, Region 10, Office of Disease Prevention and Control, Chiang Mai, July 14, 2006.

133 Human Rights Watch and TTAG interview with Nipa Ngamtrairai, December 12, 2006.

134 Ibid.

135 UNODC, "HIV/AIDS in Custodial Settings in South East Asia ," p. 47; Human Rights Watch and TTAG interview with Nipa Ngamtrairai, December 12, 2006. Médicins Sans Frontières-Belgium/Thailand provides services to undocumented people in Minburi and Bangkwang prisons, among others.

136 Wilson et al., "HIV Prevention, Care, and Treatment in Two Prisons in Thailand."

137 Human Rights Watch and TTAG interview with Jai W., Bangkok, November 30, 2006.

Access to Medication-assisted Treatment for Opioid Dependence

The United Nations office on Drugs and Crime, the World Health Organization, and the Joint United Nations Program on HIV/AIDS all recommend that methadone maintenance and other opioid substitution treatments be provided free of charge to prisoners in jurisdictions where medication-assisted treatment is available outside of prisons.[138] They specifically recommend that anyone receiving medication-assisted therapy before incarceration should be able to continue receiving treatment, and anyone else who qualifies should be able to start substitution therapy while incarcerated.[139] Although prisons must provide at least the standard of care to prisoners that is available in the general population, methadone and other medication-assisted treatment for opioid dependence are unavailable in prison.

Some prisoners can still obtain drugs inside the prison system.[140] Studies in prisons in Thailand have shown that many opioid dependent prisoners continue to inject while incarcerated, often sharing syringes with their fellow inmates, thus risking HIV and other bloodborne diseases.[141] Thai researchers have found that injection drug users in Bangkok "are at significantly increased risk of HIV infection through sharing needles with multiple partners while in holding cells before incarceration."[142] Human Rights Watch and TTAG interviews with outreach workers to prisoners and ex-inmates

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138 United Nations Office on Drugs and Crime, Word Health Organization, and UNAIDS, "HIV/AIDS Prevention, Care, Treatment and Support in Prison Settings. A Framework for an Effective National Response," 2006, para. 77; WHO, UNODC, UNAIDS, Interventions to Address HIV in Prisons. Drug Dependence Treatments (Geneva: WHO, 2007), p. 17.

139 Ibid.

140 Erika Fry, "AIDS Lingers Behind Bars," Bangkok Post, October 30, 2006.

141 Beyrer et al., "Drug Use, Increasing Incarceration Rates, and Prison-Associated HIV Risks in Thailand"; A. Buavirat et al., "Risk of prevalent HIV infection associated with incarceration among injecting drug users in Bangkok." Studies in prisons throughout the world (including Australia, Canada, Mexico, England, Wales, Scotland, and the United States) have found likewise. See, for example, David Shewan et al. , "Behavioural change amongst drug injectors

in Scottish prisons, " Social Science and Medicine, vol. 39, no. 11 (1994), 1585-1586; A. Boys et al., "Drug use and initiation in prison: results from a national prison survey in England and Wales," Addiction, vol. 97, no. 12 (2002), pp. 1551-60; Liviana M. Calzavara et al., "Prior opiate injection and incarceration history predict injection drug use among inmates,".Addiction," vol. 98 no. 9 (2003), pp. 1257-1265; P. Cravioto et al. , "Patterns of heroin consumption in a jail on the northern Mexican border: barriers to treatment access," Salud Publica de Mexico, vol. 45 (2003), pp. 181-90; Robert Heimer et al., "Methadone Maintenance in a Men's Prison in Puerto Rico: A Pilot Program,"Journal of Correctional Health Care, vol. 11, no. 3 (2005), pp. 295-305, Kate Dolan et al., "Methadone Maintenance Treatment Reduces Heroin Injection in New South Wales Prison," Drug and Alcohol Review, vol. 17 (1998), pp. 153-58.

142 Buavirat et al., "Risk of prevalent HIV infection associated with incarceration among injecting drug users in Bangkok."

documented both injection drug use in prison, as well as prison authorities' failure to address HIV-related risk among incarcerated drug users.

The provision of methadone maintenance therapy has been shown to reduce the incidence of injection in prison.[143] Likewise, stopping methadone on incarceration is associated with the likelihood of sharing injection equipment.[144]

Department of Corrections officials and HIV/AIDS clinicians providing care both inside and outside prisons offered several reasons for failure to provide access to methadone in prison. Nipa Ngamtrairai said that it was "against the law" to provide methadone in prison and that it was not needed as the number of injection drug users in prison was very low.[145] However, the government's own estimates—nearly 80 percent of inmates incarcerated for drug offences, with 60-80 percent of inmates having a drug use history[146]—and recent studies suggest that the number of injection drug users in prison is not insignificant.[147] Dr. Werakit Hanparipan from Klong Prem Central Prison, Bangkok's main prison, acknowledged that injection drug use was a persistent problem there but said that it was against hospital policy to provide methadone in prison and, further, that he believed that there was no medical reason to provide methadone in prison: "There's no significant difference between using methadone and having them go cold turkey, in terms of morbidity and mortality."[148]

Dr. Hanparipan expressed concern about methadone diversion within prison. He explained, "We treat withdrawal symptoms but we don't have substitution [medication-assisted] therapy. We don't use methadone because it's not good inside prison." Citing Australia as an example he added, "We have learned from other

143 Kate Dolan et al., "Methadone Maintenance Treatment Reduces Heroin Injection in New South Wales Prison;" Robert Heimer et al., "Methadone Maintenance in a Men's Prison in Puerto Rico;" Thomas Haig, "Randomized Controlled Trial Proves Effectiveness of Methadone Maintenance Treatment in Prison," Canadian HIV/AIDS Law and Policy Review, vol. 8, no. 3 (2003), p. 48.

144 David Shewan et al., "Behavioural change amongst drug injectors in Scottish prisons."

145 Human Rights Watch and TTAG interview with Nipa Ngamgtrairai, December 12, 2006.

146 UNODC, "HIV/AIDS and Custodial Settings in South East Asia," p. 14.

147 Buavirat et al., "Risk of prevalent HIV infection associated with incarceration among injecting drug users in Bangkok," pp. 308-326.

148 Human Rights Watch and TTAG interview with Dr. Werakit Harnparipan, July 21, 2006.

countries that it's not good inside prison because of the methadone black market."[149]

Methadone programs have been successfully created in prisons throughout the world including Indonesia, Iran, Puerto Rico, and Canada.[150] The World Health Organization advises that prison-based opioid substitution programs are relatively simple to carry out.[151] In the face of this evidence, state failure to provide available and necessary medical attention to opioid dependent prisoners, thus increasing their vulnerability to HIV and other blood borne diseases, could amount in certain cases to exposing prisoners to inhuman and degrading treatment. Such treatment would be a violation of the state's obligation to prevent such occurrence and to ensure that all detainees are treated with humanity.[152]

For those opioid-dependent prisoners unable or unwilling to access drugs in prison, many are forced to undergo abrupt opioid withdrawal (both from legally obtained methadone, as well as illicit opioids). Forced or abrupt opioid withdrawal can cause profound mental and physical pain, and can have serious medical consequences for pregnant women and their fetuses, immune-compromised people, and people suffering from comorbid medical disorders.[153] The trauma of imprisonment, coupled with severe opioid withdrawal, can also increase the risk of suicide in opioid-dependent individuals with co-occurring disorders.[154] It may also undermine

149 Ibid.

150 Robert Heimer et al., "Methadone Maintenance in a Men's Prison in Puerto Rico," S. Sefatian et al., "The harm reduction policy to help drug users in Iran," In: Proceedings of the 16th International Conference on the Reduction of Drug-Related Harm, Belfast, UK, 2005; Barbara Sibbald, "Methadone maintenance expands inside federal prisons," Canadian Medical Association Journal, vol. 167, no. 10 (2002), p.1154; Fabio Mesquita et al., "Public Health the Leading Force of the Indonesian Response to the HIV/AIDS Crises among People Who Inject Drugs," Harm Reduction Journal, vol. 4, no. 9 (2007),

151 WHO, UNAIDS, UNODC, "Evidence for action on HIV/AIDS and Injecting Drug Use. Policy Brief: Reduction of HIV Transmission in Prisons," WHO/HIV/2004.05.

152 Article 7 of the International Covenant on Civil and Political Rights (ICCPR) provides, "No one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment"; Article 10 provides, "All persons deprived of their liberty shall be treated with humanity and with respect for the inherent dignity of the human person."

153 See K. Fiscella et al., "Management of opiate detoxification in jails,"Journal of Addictive Diseases, vol. 24, 2000, pp. 61-71.

154 US Department of Health and Human Services (HHS), Substance Abuse and Mental Health Services Administration, Center for Substance Abuse Treatment, "Medication-Assisted Treatment for Opioid Addiction in Opioid Treatment Programs," Treatment Improvement Protocol (TIP) Series 43, DHHS Publication No. (SMA) 05-4048, Rockville, MD, 2005.

antiretroviral therapy for opioid-dependent drug users, for whom opioid substitution therapy is important to support adherence to ART.[155]

Continuity of Care in and between Custodial Settings

Maintaining a high level of adherence to antiretroviral medications is critical for HIV therapy to be successful, since incomplete adherence may lead to virological failure, resistance to antiretroviral medications, and therefore a reduction in available antiretroviral therapies, as well as the potential for transmission of drug resistant virus.[156] Incomplete adherence also has been associated with clinical progression of HIV disease and mortality.[157]

The government has no guidance or policy to ensure continuity of antiretroviral therapy on entry to or exit from custodial settings (pretrial detention, prisons, or inpatient drug treatment centers). Government failure to coordinate HIV/AIDS services on entry to and exit from custodial settings threatens the lives and health of people living with HIV/AIDS both within and outside custodial walls, as well as those of their sex partners and of others with whom they may use drugs.[158]

Human Rights Watch and TTAG's research found that people on antiretroviral treatment risk interruptions in treatment when they transition between prison and the community, with potential harmful effects on their health.

Difficulty with ensuring continuity of antiretroviral treatment on entry to and on release from prison was identified as a major concern by physicians providing antiretroviral therapy both in and outside prison, a Department of Corrections official working on HIV/AIDS in prison, NGOs working with drug users inside prison and after

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155 WHO, "HIV/AIDS Care and Treatment for People Who Inject Drugs In Asia. A Guide to Essential Practice."

156 See World Health Organization, WHO Regional Offices for South-East Asia and the Western Pacific, "HIV/AIDS Care and Treatment for People Who Inject Drugs In Asia. A Guide to Essential Practice" p. 34 (citing studies).

157 See studies cited in ibid.; see also Curtis, ed., "Delivering HIV Care and Treatment for People Who Use Drugs," p. 27.

158 The transfer of prisoners within the prison system also presents problems with ensuring continuity of antiretroviral treatment. Physicians at MSF reported that five of the prisoners to whom they had provided antiretroviral treatment were lost to follow up when they were transferred to other prisons. They noted that while efforts had been made to communicate the health needs of prisoners with HIV/AIDS within the system, "the reality is that we do not know what care is provided for the five patients from our cohort who have been transferred to other prisons." Wilson, et al., "HIV Prevention, Care, and Treatment in Two Prisons in Thailand."

release, and drug users. HIV clinicians in Satun, Chiang Mai, Bangkok, and Samut Prakhan provinces reported that it was difficult to monitor ART for patients who were incarcerated or entered drug treatment programs, and that many pre- and post-trial detention facilities had no one to monitor ART for prisoners.[159] Several clinicians said that family members sometimes brought ART to incarcerated relatives, but that they did not monitor their care because the prisons were outside of the respective hospital coverage areas.[160] Dr. Praphan Phanuphak, director of the Thai Red Cross AIDS Research Centre and co-director of HIV-Netherlands Australia Thailand Research Collaboration, described the ad hoc nature of these referrals. He said that, if a patient were incarcerated, they would not know unless informed by their families. He added, "Whether people get ART in prison depends on where the prison is and whether their families are taking care of them. Usually in prison … people don't want to tell anyone about their HIV status or that they're taking antiretroviral drugs."[161]

Nipa Ngamtrairai said that antiretroviral treatment was sometimes interrupted for people who were receiving antiretroviral treatment in one province and imprisoned in another. According to Ngamtrairai, "If a person is on ART in one province, and arrested in a second province, the second won't provide ART. I have to fight for prisoners to get access to ART, or get help from MSF." She added, "We try not to transfer prisoners within the prison system because that creates problems with continuity of care. This policy applies to all diagnoses, not just HIV. It's not a written policy, but something we discuss in staff meetings. There are no written guidelines on this… There is an official order that you can't move prisoners on ART. [162]

159 Human Rights Watch and TTAG Interview with Dr. Somsak Wasuwithitkul, Satun province, July 8, 2006; Human Rights Watch and TTAG interview with Dr. Virat Klinbuayaem, Sanpathong, July 14, 2006; Human Rights Watch and TTAG interview with Dr. Tasana Leusaree, HIV/AIDS program manager, Region 10, Office of Disease Prevention and Control, Chiang Mai, July 12, 2006; Human Rights Watch and TTAG interview with Tippaporn Upsornthanasombat, social worker, Region 10, Office of Disease Prevention and Control, Chiang Mai, July 14, 2006l Human Rights Watch and TTAG interview with Dr. Praphan Phanuphak, July 20, 2006; Human Rights Watch and TTAG interview with Dr. Sittichai Kulpornsirikul, December 4, 2006.

160 See, for example, Human Rights Watch and TTAG interview with Dr. Virat Klinbuayaem, Sanpathong, July 14, 2006; Human Rights Watch and TTAG interview with Dr. Somsak Wasuwithitkul, deputy director, Langhu Hospital, Langhu, July 8, 2006; Human Rights Watch and TTAG interview with Dr. Sitthisat Chiamwongpaet, director general, Health Department, Bangkok Metropolitan Administration, Bangkok, December 4, 2006.

161 Human Rights Watch interview with Dr. Praphan Phanuphak, July 20, 2006.

162 Human Rights Watch and TTAG interview with Nipa Ngamtrairai, December 12, 2006.

Inmates who received antiretroviral therapy while incarcerated faced barriers to continuing care on release. Health care workers in Klong Prem prison hospital in Bangkok reported that prisoners frequently could not obtain ART outside prison and that many former inmates continued to receive ART from the prisoner pharmacy for months following discharge because they could not successfully transfer their cases to hospitals outside of prison.[163] NGOs working with prisoners and ex-prisoners reported that many ex-prisoners did not have identity cards; without these they could not establish eligibility for ART and other healthcare services under the national health insurance scheme.[164] When asked how a person might seek services if he or she had no identity card, Ngamtrairai replied that in Bangkok, "They can contact MSF or Alden House [a Bangkok-based NGO] with the problem."[165] In some cases (as in the case of Jai W., described above), NGOs like MSF can help fill these gaps, but this is not always the case.

Klong Prem healthcare workers said that it was not enough to simply provide ART, and that more needed to be done to improve the entire continuum of care throughout the cycle of incarceration, including pre-entry and upon release.[166]

Compulsory Drug Treatment Centers

As of March 2005, Thailand had 49 compulsory drug treatment centers, to which drug users were placed pursuant to the 2002 Narcotic Drug Rehabilitation Act. At the end of 2004, nearly 10,000 drug users were in treatment at these centers. [167]

Staff at compulsory drug treatment facilities also identified access to ART for HIV-positive patients and continuity of care for patients receiving ART as problems.[168]

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163 Human Rights Watch and TTAG interview with social worker, Klong Prem Central Prison, Bangkok, July 21, 2006.

164 Some ex-prisoners have lost their identity cards and have difficulty replacing them. Some Thai nationals have never had an identity card, and some ethnic minorities' identity cards do not entitle them to a full range of healthcare services. Email communication from Paul Cawthorne, head of mission, MSF-Belgium, to TTAG, October 21, 2007; see also D. Wilson et al., "HIV Prevention, Care, and Treatment in Two Prisons in Thailand."

165 Human Rights Watch and TTAG interview with Nipa Ngamtrairi, December 12, 2006.

166 Comments by Mrs. Wichuda Kongpromsuk, nurse, and Ms. Parichart Wonglue, social worker, Klong Prem Central Prison, at meeting on Human Rights Watch/TTAG research on access to HIV/AIDS treatment for injection drug users in Thailand, Bangkok, May 4, 2007.

167 UNODC, "HIV/AIDS and Custodial Settings in South East Asia," p. 46.

Montol Kaewkaw, director of the Ladlumkaew Treatment Center, a secure compulsory drug treatment center run by the Ministry of Justice, recognized the importance of ensuring continuity of HIV and other medical care on exit from the treatment facility. Kaewkaw had taken the initiative to try to incorporate patient follow up after release, but said that his center lacked the capacity to ensure patient referrals in all cases, and that they needed support from other agencies to do so. Kaewkaw suggested that there be a national policy to assist with continuity of care for patients in need of HIV services on release. "We should have a role to cooperate with the hospitals," Kaewkaw said, "For example, one former patient lives in [name of town withheld], and we should sent a letter [to the hospital], because that person needs ART in [town]." But, he added, "We counsel and help as much as we can. It's a national problem, which we cannot resolve at our level. We need cooperation from all agencies."[169]

168 Human Rights Watch interview with First Lieutenant Dr. Smith Vatanatunyakum, deputy director, Thanyarak Institute, Pathumthani, July 24, 2006; Human Rights Watch and TTAG interview with Montol Kaewkaw, director, Ladlumkaew Treatment Center, Ladlumkaew, December 8, 2006.

169 Human Rights Watch and TTAG interview with Montol Kaewkaw, December 8, 2006.

Human Rights Standards

Thailand is a party to both the International Covenant on Economic, Social and Cultural Rights (ICESCR) and the International Covenant on Civil and Political Rights (ICCPR).[170] As such it has obligations to respect, protect, and fulfill the rights protected under both treaties for all those within its jurisdiction, including HIV-positive drug users. In particular it must respect the right of everyone to "the enjoyment of the highest attainable standard of physical and mental health,"[171] the right to privacy,[172] and the right of all detainees to be treated with dignity.[173] Thailand also recognizes in its constitution that everyone has "equal rights to receive quality public health services."[174] Thailand has obligations to ensure drug users can enjoy the right to health without fear of punishment and discrimination, including in prison, and can access voluntary, affordable, and quality medical treatment.[175] It also has obligations to take positive measures to ensure equal access to HIV/AIDS-related information and prevention, care, and treatment services for all people living with and at risk of the disease.[176]

The Right to Health

The right to health includes both freedoms and entitlements: freedom from unjustified interference by the State directly or indirectly with an individual's health; and entitlements to a particular, nondiscriminatory health care.[177] Respect for the

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170 International Covenant on Civil and Political Rights (ICCPR), G.A. res. 2200A (XXI), 21 U.N. GAOR Supp. (No. 16) at 52, U.N. Doc. A/6316 (1966), 999 U.N.T.S. 171, entered into force March 23, 1976, arts. 6(1), 7, 9, and 14(1). Thailand became a party to the ICCPR on October 29, 1996. International Covenant on Economic, Social and Cultural Rights (ICESCR), adopted December 16, 1966, entered into force January 3, 1976, GA Res. 2200 (XXI), 21 UN GAOR, 21st Sess., Supp. No. 16, at 49, UN Doc. A/6316 (1966), art. 12. Thailand became a party to the ICESCR on September 5, 1999.

171 ICESCR, art. 12.

172 ICCPR, art. 17.

173 ICCPR, art. 7.

174 Constitution of Thailand, Part 9, http://www.parliament.go.th/parcy/sapa_db/sapa25-upload/25-20070517151204_2007.pdf (accessed August 26, 2007).

175 Committee on Economic, Social and Cultural Rights, General Comment 14, UN Doc. E/C.12/2000/4, adopted August 11, 2000, paras. 34 and 36.

176 Ibid.

177 Ibid., para 33.

right to health also incorporates respect for other rights such as the right to privacy and the right to seek, receive, and impart information. In fulfilling the right to health, states are specifically obliged to take those steps necessary for "the prevention, treatment and control of epidemic … diseases."[178] This includes "the establishment of prevention and education programmes for behaviour-related health concerns such as sexually-transmitted diseases, in particular HIV/AIDS."[179] Laws and policies that "are likely to result in … unnecessary morbidity and preventable mortality" may violate the obligation to respect the right to health.[180]

The UN Committee on Economic, Social and Cultural Rights has identified four essential elements of the right to health: availability; accessibility; acceptability; and quality.[181] The availability requirement means that states must make available "[f]unctioning public health and health-care facilities, goods and services, as well as programmes." The accessibility requirement has four overlapping dimensions: non-discrimination, physical accessibility, economic accessibility, and information accessibility (people have the opportunity to seek, receive, and impart information about health issues). Acceptability means that health services are medically and culturally appropriate. Finally, health services must be scientifically and medically appropriate and of good quality.

The right to the highest attainable standard of health outlined in the ICESCR is subject to "progressive realization," under which states parties have a "specific and continuing obligation to move as expeditiously and effectively as possible towards the full realization of [the right]."[182] States must guarantee certain core obligations as part of the right to health. These include ensuring non-discriminatory access to health facilities, especially for vulnerable or marginalized groups; providing essential drugs; ensuring equitable distribution of all health facilities, goods and services; adopting and implementing a national public health strategy and plan of action with clear benchmarks and deadlines; ensuring reproductive, maternal, and

178 ICESCR, art. 12 (2) c.

179 General Comment 14, para. 16.

180 Ibid., para. 50.

181 Ibid., para. 12.

182 Ibid., paras. 30, 31.

child care; taking measures to prevent, treat, and control epidemic and endemic diseases; providing education and access to information for important health problems; and providing appropriate training for health personnel, including education on health and human rights.[183] To justify the failure to meet at least minimum core obligations as based on a lack of available resources, a state party "must demonstrate that every effort has been made to use all resources that are at its disposition in an effort to satisfy, as a matter of priority, those minimum obligations."[184]

Rights of Detainees to Health Care

International human rights law clearly affirms that prisoners retain fundamental rights and freedoms guaranteed under human rights law, except the right to liberty, although they may be subject to restrictions that are commensurate with a closed environment.[185] However, the conditions of confinement should not aggravate the suffering inherent in imprisonment.[186] Prisoners, therefore, like all other persons, enjoy the right to the highest attainable standard of health and in particular the right to be treated with dignity and protection against torture and cruel, inhuman, or degrading treatment or punishment.[187]

International law requires states to take measures to ensure that conditions of incarceration conform to international human rights norms and standards. The prohibition on inhuman or degrading treatment specifically "compels authorities not only to refrain from provoking such treatment, but also to take the practical preventive measures to protect the physical integrity and the health of persons who

183 Ibid., paras. 43 and 44; also ibid., para. 12.

184 Committee on Economic, Social and Cultural Rights, General Comment 3: The Nature of States Parties Obligations (Art. 2)(1), UN Doc. E/1991/23, para. 10.

185 United Nations Human Rights Committee, "General Comment No. 21: Humane treatment of persons deprived of liberty (Art. 10)," (Adopted April 10, 1992) Compilation of General Comments and General Recommendations Adopted by Human Rights Treaty Bodies, HRI/GEN/1/Rev.7, para. 3; European Court of Human Rights (ECHR), Gelfmann v. France, no. 25875/03, Judgment of 14 December 2004, para. 50.

186 Ibid.

187 International Covenant on Civil and Political Rights, arts. 7 and 10. On October 2, 2007, Thailand also acceded to the Convention against Torture and Other Cruel, Inhuman and Degrading Treatment or Punishment, G.A. res. 39/46, [annex, 39 U.N. GAOR Supp. (No. 51) at 197, U.N. Doc. A/39/51 (1984)], entered into force June 26, 1987, although it was not a party at the time that the research for this report was conducted.

have been deprived of their liberty."[188] It has been recognized that failure to provide adequate health care or medical treatment to a detainee in prison may contribute to conditions amounting to "inhuman or degrading treatment."[189]

Key international instruments establish the general consensus that prisoners are entitled to a standard of health care equivalent to that available in the general community, without discrimination based on their legal status.[190] The UN Committee on Economic, Social and Cultural Rights, in its commentary on the right to health, repeatedly stresses the importance of states' obligations to ensure access to health facilities, goods, and services to all persons, "especially the most vulnerable or marginalized sections of the population" without discrimination on the basis of (inter alia) "health status including HIV/AIDS" or "political, social or other status" that "has the intention or effect of nullifying or impairing equal enjoyment of the right to health." The Committee notes in particular government obligations to "refrain from denying or limiting equal access for all persons, including prisoners or detainees … to preventive, curative, and palliative health services," and to abstain from "enforcing discriminatory practices as State policy."[191]

188 ECHR, Pantea v. Romania, no. 33343/96, Judgment of 3 September 2003, para 189; ECHR, Gelfmann v. France, para. 50.

189 See European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment, 3rd General Report on the CPT's activities covering the period January 1 to December 31, 1992, para 31; ECHR, Melnik v. Ukraine, no. 72286/01, Judgment of March 28, 2006.

190 United Nations Basic Principles for the Treatment of Prisoners, UN General Assembly Resolution 45/111 (1990); WHO Guidelines on HIV Infection and AIDS in Prisons (1999), arts. A (4) and C (ii); the Body of Principles for the Protection of All Persons Under any form of Detention or Imprisonment, UN General Assembly Resolution 43/173 (1988). Although these instruments are not legally binding in and of themselves, they provide authoritative guidance to states on the interpretation of relevant treaty obligations.

191Committee on Economic, Social and Cultural Rights, General Comment 14, UN Doc. E/C.12/2000/4, adopted August 11, 2000, paras. 12, 18, 34.

Conclusion

In June 2007, Thailand introduced its 2007-2011 National AIDS Plan which recognizes its failures in combating HIV and AIDS among drug users and prisoners, and proposes to scale up efforts to ensure access to HIV and AIDS prevention, care, and treatment services to them.

Thailand's success in addressing HIV/AIDS in the broader population is due in large part to its decision to engage people living with and at high risk of HIV/AIDS and their networks as equal partners in its response. If Thailand is to make progress in its efforts to fight HIV and AIDS among drug users, it must engage people who use drugs as equal partners in its plans and in the same spirit as it has other people living with and at high risk of HIV/AIDS. Open communication about methadone and about drug use, without fear of negative consequences, is critical to receiving good care. Thailand must therefore follow its commitments with prompt and forceful action to address the violations of human rights against drug users and prisoners by law enforcement and healthcare providers, and the widespread prejudices by government and civil society against them.

If Thailand takes such steps, it could reach its goal of ensuring universal access to HIV/AIDS services to all those who need them. Otherwise, it will miss an opportunity to reverse the course of its epidemic, and at the cost of thousands of drug users' lives.

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Deadly Denial

Barriers to HIV/AIDS Treatment for People Who Use Drugs in Thailand

Thailand, globally regarded as an HIV/AIDS response "success story" for its aggressive HIV prevention programs and efforts to provide universal access to HIV treatment, has failed to prevent or treat HIV among those at the highest risk of infection and on whom the disease continues to have the most devastating impact—people who use drugs. For two decades, injecting drug users have suffered Thailand's highest HIV prevalence and benefited little from its programs.

People who use drugs in Thailand face serious obstacles in obtaining health care. The government has delivered life-saving antiretroviral therapy (ART) to more than 80 percent of people in need in Thailand, but it has systematically failed to extend this treatment to drug users. Many health care providers do not know or do not follow HIV/AIDS treatment guidelines, and continue to deny ART to people who use drugs. Routine harassment and arrest by police (sometimes at or near methadone clinics), as well as the lasting effects of the 2003 drug war, create major obstacles to outreach work.

Thailand has made a number of public commitments to address its failure to combat HIV/AIDS among people who use drugs, pledging to "act quickly" to scale up harm reduction and comprehensive HIV/AIDS prevention, care, and treatment services to them. These commitments, however, remain unfulfilled.

Thailand must take prompt and forceful action to address the systematic violations of human rights against people who use drugs and prisoners by law enforcement and health care providers, as well as the widespread prejudices by government and civil society against them. Failure to do so violates Thailand's constitutional and international obligations and encourages the course of its AIDS epidemic among some of Thailand's most marginalized.