

Drugs, punitive laws, policies, and policing practices, and HIV/AIDS

Too often, drug users suffer discrimination, are forced to accept treatment, marginalized and often harmed by approaches which over-emphasize criminalization and punishment while under-emphasizing harm reduction and respect for human rights.

—UN High Commissioner for Human Rights, 2009¹

In many countries around the world, drug control efforts result in serious human rights abuses: torture and ill treatment by police, mass incarceration, extrajudicial killings, arbitrary detention, denial of essential medicines and basic health services. Drug control policies, and accompanying enforcement practices, often entrench and exacerbate systematic discrimination against people who use drugs, and impede access to controlled essential medicines for those who need them for therapeutic purposes. Local communities in drug-producing countries also face violations of their human rights as a result of campaigns to eradicate illicit crops, including environmental damage, displacement and damage to health from chemical spraying. These abuses are widespread and systematic.

These abuses are cause for considerable concern in themselves, but they are also impeding an effective response to the AIDS epidemic: by denying people who use drugs access to proven, effective HIV prevention, care, and treatment services and by contributing to at least one million people living with HIV/AIDS going without adequate treatment to address moderate to severe pain.

Outside of sub-Saharan Africa, as many as 30 percent of all new HIV infections occur among people who inject drugs and within sub-Saharan Africa, injection drug use is increasing. In some countries, in particular in Central and Eastern Europe and East Asia, injecting drug use is the primary driver of HIV epidemics.

International health and drug control agencies—including the UN Office on Drugs and Crime, UNAIDS, UNICEF, UNDP, and the World Health Organization—all endorse comprehensive harm reduction services, including needle and syringe exchange, medication assisted therapy (for example, with methadone), and peer outreach and education programs, as best practice interventions essential to address HIV among people who use drugs, including in places of detention.

Notwithstanding broad endorsement and overwhelming scientific evidence that they work, these approaches remain out of reach for the vast majority of people who need them.

In many countries, criminal laws, disproportionate penalties, and law enforcement practices drive people away from lifesaving HIV services that do exist. Unnecessarily strict and complex regulations impede access to controlled essential medicines—such as methadone from drug dependence treatment, or morphine for pain relief—with dire consequences for the health and lives of millions of people worldwide. According to the WHO, tens of millions of people suffer untreated moderate to severe pain, including one million HIV/AIDS patients and 5.5 million terminal cancer patients. And if opioid substitution therapy was made readily available globally, it could prevent up to 130,000 new HIV infections annually, reduce the spread of hepatitis C and other blood-borne diseases, and decrease deaths from opioid overdose by 90 percent.

Governments have a duty under international law to take steps to reduce supply of and demand for controlled drugs. In doing so, they must ensure that these efforts are balanced with obligations to ensure adequate availability of controlled drugs for medical purposes, and that these steps are consistent with states' human rights obligations. In particular, states should avoid policies and programs that compromise the health and human rights of people who use drugs, including those that increase their vulnerability to HIV infection or impede access to HIV treatment and care. Unfortunately, punitive approaches have taken priority in law, practice, and funding in the response to drug use and drug dependence all over the world. Criminal laws, disproportionate penalties, and law enforcement practices have resulted in negative health outcomes and have affected a wide range of other rights.

Criminal laws, policies and law enforcement approaches

Criminal laws relating to drug use and possession for personal use

In almost every country in the world possession of drugs for personal consumption is a crime. In many, drug use itself is a crime. The implications for those who have a dependency—a chronic, relapsing medical condition—are particularly serious. Individuals have a right to obtain lifesaving health services without fear of punishment or discrimination, but in some countries, many people who inject drugs do not carry sterile syringes or other injecting equipment, even though it is legal to do so, because possession of such equipment can mark an individual as a drug user, and expose him or her to punishment on other grounds.^[i] Many do not seek treatment or attend harm reduction services, again, for fear of arrest and conviction. Aside from the obvious harms associated with imprisonment, the consequences of obtaining a criminal record are considerable and can affect access to future employment, education and even social services such as housing. Criminal status also exposes people who use drugs to police abuse including beatings, extortion and even torture.

Drug paraphernalia laws

In many countries, carrying drug paraphernalia such as needles and syringes, crack pipes, and even foil for smoking heroin is illegal. This can deter safer drug use as users fear attracting police attention. It can also deter the initiation of harm reduction services as service providers worry about the legal implications of providing clean equipment.

'Incitement', 'encouragement', or 'aiding and abetting' laws

Laws that create criminal penalties for incitement to use drugs or facilitating/encouraging drug use exist in many countries. Such laws are not often based on the reality of drug use and initiation (which is often between peers, siblings and friends who are also using) and can act as a deterrent to harm reduction services. Harm reduction providers are frequently accused of facilitating drug use.^[ii]

Arbitrary age restrictions on harm reduction services

Injecting drug users who are under 18 are often denied access to lifesaving harm reduction services. In many countries this ignores the fact that children as young as 10 or 12 are known to inject drugs.^[iii]

Drug user registries

Once they come to the attention of health services, drug users in many countries are added to 'registries' where their status as a drug user may be made known to others. Drug user registration serves as a form of

state control over people who are dependent on drugs and imposes restrictions on their rights. The process brands people as drug users for years, sometimes indefinitely, regardless of whether they cease using drugs.^{iv} In China, for example, methadone treatment patients are added to government registries linked to their identification documents and accessible to the police. In Thailand, once registered, drug users remain under surveillance by police and anti-drug agencies, and information about patient drug use is shared. Fear of registry discourages individuals from accessing care, even though it is free.^v In Russia, people who enroll in public drug treatment programs are added to registries (those who can afford to seek private drug treatment are not). Being listed on the registry can lead to loss of employment, housing, and even child custody. Faced with these consequences, many people don't see public drug treatment as a viable option.

Policing practices

Appropriate, human rights compliant policing is essential for effective drug policies and positive health outcomes for drug users. Unfortunately, in country after country, the experience is often the opposite, partly due to the poor laws being enforced and partly due to policing practices. In many places, police target harm reduction services, seeing easy opportunities to harass, entrap, and extort clients. There are systemic reasons that facilitate police abuse of drug users. In many countries, police must fulfill periodic "work plans" or arrest quotas as a criterion for promotion or funding. The pressure on police officers to meet arrest quotas as a measure of success exacerbates police abuse by encouraging them to seek out easy targets, like drug users, to meet their work goals.^{vi}

Police presence at or near harm reduction programs drives people away from these services out of fear of arrest or other punishment.^{vii} In Ukraine, for example, drug users have reported being arrested multiple times at legal needle exchange sites. Individuals have been severely beaten for possessing syringes at or near needle exchange points.^{viii}

In Georgia, drug crackdowns in 2007 resulted in 4 percent of Georgia's male population being tested for drugs, many under forced conditions. Thirty-five percent of these went on to be imprisoned on a drug-related charge.^{ix} In Thailand, the 2003 'war on drugs' that resulted in over 2,800 extrajudicial killings, has had a lasting impact on drug users' access to fundamental health care services. Studies reported a significant decline in the number of people seeking treatment for drug use during the 'war on drugs', and also reported that a significant percentage of people who had formerly attended drug treatment centers went into hiding.^x Years later, many people who use drugs still refrained from seeking treatment at public hospitals for fear that their drug use (past or current) will be shared with police. This fear is not unfounded. Public hospitals and drug treatment centers collect and share information about individuals' drug use with law enforcement, both as a matter of policy and in practice.^{xi}

Disproportionate drug penalties and discriminatory application of drug control measures

The penalties for possession for personal use, or with intent to supply in many countries are severe, from lengthy prison sentences to the death penalty. In the United States, three strikes legislation in some states can result in life sentences for petty and non-violent drug crimes.^{xii} In many countries, people are sentenced to death and executed for drug offences, sometimes for possession of relatively small amounts of illicit drugs.^{xiii} In some countries, such sentences are mandatory. Such penalties are entirely disproportionate to the crimes involved; mandatory sentences have also been shown ineffective in reducing drug consumption and drug-related crime.^{xiv} The impact of drug control is often disproportionately focused on vulnerable groups and marginalized communities: peasant farmers, small time dealers, low level drug offenders, and racial and ethnic minorities or indigenous peoples. In the United States, African American men and women are sent to

prison for drug charges at rates many times that of their white counterparts and the application of mandatory minimum sentencing often subjects them to equal or harsher penalties than the principals of the drug trade.^{xv} In Brazil, the vast majority of those killed by police in their ongoing war against drugs have been poor, black, young boys from favela communities, for whom involvement in the drug gangs is one of the few viable opportunities for employment.^{xvi}

Coerced and compulsory drug dependence treatment

International health and drug control agencies—including the UN Office on Drugs and Crime, UNAIDS, and the World Health Organization—all endorse comprehensive, evidence-based drug treatment services, both inside and outside prisons, as essential to prevent HIV, and to support HIV/AIDS care and treatment services, for people who use drugs. In some countries, however, people who identified as or suspected to be drug users may be coerced or even compelled to spend years in drug treatment centers, regardless of whether they need treatment, and without due process of law. **Often run by military or public security facilities and staffed by people with no medical training, these centers rarely provide treatment based on scientific evidence.**

In China, as of 2005, some 350,000 drug users were interned in mandatory drug-detoxification and "re-education through labor" centers, where they can be held without due process for up to three years. Treatment consists of unpaid, forced labor and psychological and moral re-education: marching in formation, repetitive drills and rote repetition of slogans (such as "drug use is bad, I am bad").^{xvii}

Since 2003, thousands of people in Thailand have been coerced into "drug treatment" centers run by security forces. Before "treatment" even begins, people are held for "assessment" for extended periods in prison. In the centers, military drills on the orders of security personnel are a mainstay of so-called "treatment".

People who use drugs in some facilities in Russia have been subjected to "flogging therapy," handcuffed to beds during detoxification and denied medication to alleviate painful withdrawal symptoms. Those who enter treatment voluntarily are consigned to locked wards, in some cases with fatal consequences.^{xviii} In 2006, 46 young women died in a fire in a Moscow substance abuse hospital, where staff had abandoned residents to struggle against locked windows and doors.^{xix}

In Singapore, according to a government report distributed in March 2009, people who use drugs can be arbitrarily detained for extended periods of time and caned if they relapse, even though relapse is a common milepost on the road to recovery.^{xx}

Criminal law, law enforcement, and HIV/AIDS

UN health and drug control agencies—including UNAIDS, WHO, UNODC, and INCB—have endorsed and promoted a wide range of interventions for the prevention, treatment, and care of HIV among people who use drugs, including opioid substitution therapy and ensuring access to and use of needle and syringe exchange programs, as essential components of HIV/AIDS programs for people who use drugs. Yet punitive laws, policies, and practices keep many drug users from receiving these lifesaving services, even in countries where they are legal.

Research in several countries has established that criminal laws proscribing syringe possession and associated policing practices targeting people who use drugs increase the risk of HIV in both direct and

indirect ways.^{xxi} This reality is reflected in the International Guidelines on HIV and Human Rights, which state that:

States should review and reform criminal laws and correctional systems to ensure that they are consistent with international human rights obligations and are not misused in the context of HIV or targeted against vulnerable groups

...

Criminal law should not be an impediment to measures taken by States to reduce the risk of HIV transmission among injecting drug users and to provide HIV-related care and treatment for injecting drug users.^{xxii}

HIV treatment is also affected by a legal and policy environment that criminalizes and stigmatizes a population at elevated risk. In many countries where people who use drugs represent a significant, or even a majority, of those living with HIV, their access to treatment is disproportionately low relative to other people living with HIV. In China, figures from 2006 showed that while 48 percent of HIV cases were people who inject drugs, this group represented only 1 percent of those accessing ART. In Malaysia, 75 percent of HIV cases were among people who inject drugs, while only 5 percent of injectors had access to ART.^{xxiii} A similar discrepancy was found in a WHO Europe study of European countries, particularly in Eastern Europe.^{xxiv}

Drug law and policy reform and the health and human rights of people who use drugs

Many countries have taken measures to protect drug users' right to the highest attainable standard of health by reforming drug laws and policing practices to ensure drug users' access to HIV prevention and other health services. These include measures to decriminalize possession of drug paraphernalia and of possession and use of small amounts of drugs for personal use; to ensure implementation of such harm reduction measures as opioid substitution treatment, sterile syringe programs, supervised consumption facilities, and heroin prescription programs.

The UN drug conventions grant some flexibility with respect to penalization of possession and use of controlled substances.^{xxv} According to the International Narcotics Control Board, the treaty body charged with monitoring the drug control treaties and interpreting their provisions, “[t]he international drug control treaties do grant some latitude with regard to the penalization of personal consumption-related offences. Parties to the 1961 Convention are under an obligation not to permit the possession of drugs for personal non-medical consumption. Parties to the 1988 Convention are required to establish as criminal offences activities preparatory to personal consumption, **subject to each party's constitutional principles and the basic concepts of its legal system.**”^{xxvi} The INCB has, for example, concluded that Portugal's 2001 drug law reform decriminalizing the possession of small amounts of controlled drugs for personal use and drug use itself was consistent with the international drug control treaties.^{xxvii} UNODC has also raised concern about the harmful consequences of drug criminalization on the health and human rights of people who use drugs, and have encouraged the use of creative approaches to drug enforcement, including stopping the incarceration of petty offenders, and reforming performance indicators that promote high numbers of arrests (as compared to targeting violent criminals or high volume dealers).^{xxviii}

Numerous reviews—including that done by the UNDCP Legal Affairs Section at the request of the INCB—have similarly concluded that the implementation of such harm reduction measures as opioid substitution treatment, sterile syringe programs, supervised consumption facilities, and heroin prescription programs are consistent with and not in violation of, state obligations under the three UN Drug Control Conventions.^{xxix}

Concerns about the harmful effects of a criminal justice approach on the health and human rights of people who use drugs have prompted a number of governments to decriminalize possession of small quantities of drugs for personal use either by law or in practice. Spain, Portugal, and Italy, for example, do not consider possession of drugs for personal use a punishable offense; in the Netherlands and Germany, possession for personal use is illegal, but guidelines are established for police and prosecution to avoid imposing punishment.^{xxx} Many Latin American countries (including Brazil, Mexico, Argentina, and Colombia) have decriminalized possession for personal use, either by court decree or through legislative action, moves supported by high profile politicians including ex-presidents.^{xxxi} Portugal has decriminalized all possession for personal use.^{xxxii}

In the United States, some jurisdictions have protected drug users' access to harm reduction services through court orders barring police from arresting needle exchange participants for drug possession based on residue in used syringes, or through police department orders directing police not to patrol areas near syringe exchange sites.^{xxxiii} At least twenty-seven cities worldwide, including in Switzerland, Germany, Australia, and Canada have established supervised injection sites that permit drug users to inject in a safe, hygienic environment without risk of arrest or prosecution for onsite possession of illegal drugs.^{xxxiv} At least 10 countries in Europe and Central Asia have prison-based needle exchange programs, including Iran, Moldova and Kyrgyzstan.^{xxxv}

ⁱ High Commissioner calls for focus on human rights and harm reduction in international drug policy, Press release, 10 March 2009, <http://www.unhchr.ch/hurricane/hurricane.nsf/viewo1/3A5B668A4EE1BBC2C12575750055262E?opendocument>

ⁱⁱ A survey of drug users in five Russian cities, for example, found that 40 percent routinely did not carry injection equipment, in part out of fear of attracting police attention. Jean-Paul C. Grund, 'Central and Eastern Europe', in HIV AND AIDS: A GLOBAL VIEW, Karen McElrath, (ed) (Westport, Connecticut: Greenwood Press, 2002), pp. 41-67.

ⁱⁱⁱ Young people and injecting drug use in selected countries of central and eastern Europe, Eurasian Harm Reduction Network, 2009, pp. 62-65.

^{iv} See *ibid* pp. 28-31.

^v The Effects of Drug User Registration Laws on People's Rights and Health, Key Findings from Russia, Georgia, and Ukraine, Open Society Institute, October 2009 http://www.soros.org/initiatives/health/focus/ihrd/articles_publications/publications/drugreg_20091001/drugreg_20091001.pdf

^{vi} Human Rights Watch, "Deadly Denial, Barriers to HIV/AIDS Treatment for People Who Use Drugs in Thailand," 2007, p. 20

^{vii} See, e.g., Human Rights Watch, "Rhetoric and Risk: Human Rights Abuses Impeding Ukraine's Fight Against AIDS," Vol. 18, No. 2(D), pp. 19-23; "Lessons Not Learned: Human Rights Abuses and HIV/AIDS in the Russian Federation," Vol. 16, No. 5(D), April 2004; "Fanning the Flames: How Human Rights Abuses Are Fuelling the AIDS Epidemic in Kazakhstan", vol. 15, No. 4(D), June 2003.

^{viii} See also studies cited in the Human Rights Watch reports: "Rhetoric and Risk: Human Rights Abuses Impeding Ukraine's Fight Against AIDS," Vol. 18, No. 2(D), pp. 34-40; "Lessons Not Learned: Human Rights Abuses and HIV/AIDS in the Russian Federation," Vol. 16, No. 5(D), April 2004 pp. 28-31; "Fanning the Flames: How Human Rights Abuses Are Fuelling the AIDS Epidemic in Kazakhstan", vol. 15, No. 4(D), June 2003, pp. 32-34; "Not Enough Graves: The War on Drugs, HIV/AIDS, and Violations of Human Rights," vol. 16, No. 8(C) (June 2004), pp.36-42.

^{ix} Human Rights Watch, "Rhetoric and Risk: Human Rights Abuses Impeding Ukraine's Fight Against HIV/AIDS."

^x Otiashvili, D., "Georgian Drug War – Ignoring Evidences, Neglecting Human Rights." Presented at the International Harm Reduction Association's 19th Annual conference in Barcelona, Spain, May 14th, 2008.

^x "Not Enough Graves," pp. 36-37. Researchers have also found that the government crackdown on drug users was likely to discourage drug users from obtaining HIV testing and other medical services. Tassanai Vongchak et al., "The influence of Thailand's 2003 'war on drugs' policy on self-reported drug use among injection drug users in Chiang Mai, Thailand," *International Journal of Drug Policy*, No. 16 (2005), pp. 115-121.

^{xii} Human Rights Watch and Thai AIDS Treatment Action Group, “Deadly Denial: Barriers to HIV/AIDS Treatment for People Who Use Drugs in Thailand”, November 2007, pp. 20-24.

^{xiii} See for example, Justice Policy Institute, “Still Striking Out: Ten years of California’s three strikes policy”, 2004, http://www.justicepolicy.org/images/upload/04-03_REP_CAStrikingOut_AC.pdf; and Justice Policy Institute, ‘Three Strikes and You’re Out: An examination of the impact of 3-strike laws 10 years after their enactment’, 2004, http://www.soros.org/initiatives/justice/articles_publications/publications/threestrikes_20040923/three_strikes.pdf.

^{xiv} The right to life may be infringed in the context of the death penalty, but only in very specific circumstances. The death penalty for drugs does not meet the required threshold of ‘most serious crimes’ under which the death penalty is allowed only as an “exceptional measure” where “there was an intention to kill which resulted in the loss of life.” For a discussion of this issue see Rick Lines ‘The Death Penalty for Drug Offences: A Violation of International Human Rights Law’ International Harm Reduction Association, 2007.

^{xv} See, e.g., T Gabor and N Crutcher ‘Mandatory minimum penalties: Their effects on crime, sentencing disparities, and justice system expenditures’. Ottawa: Justice Canada (Research and Statistics Division), January 2002.

^{xvi} See Human Rights Watch, “Decades of Disparity: Drug Arrests and Race in the United States,” 2009; Human Rights Watch, “Targeting Blacks: Drug Law Enforcement and Race in the United States,” 2008; American Civil Liberties Union, “Break the Chains,” and the Brennan Center at NYU School of Law, “Caught in the net: The impact of drug policies on women and families,” New York, 2006.

^{xvii} ANCED and Forum DCA, ‘Report of Civil Society on the Rights of the Child and the Adolescent in Brazil, Alternative Report Submitted to the Committee on the Rights of the Child’, 2004, p. 76. (On file with the authors); see also Luke Dowdney, ‘Children of the Drug Trade: a case study of children in organised armed violence in Rio de Janeiro’, *7 Letras*, 2003, p. 167.

^{xviii} Human Rights Watch, “An Unbreakable Cycle: Drug Dependency Treatment, Mandatory Confinement, and HIV/AIDS in China’s Guangxi Province,” December 2008, <http://www.hrw.org/en/reports/2008/12/09/unbreakable-cycle-0>; The UN Special Rapporteur on Torture has stated that this system “can also be considered as a form of inhuman or degrading treatment or punishment, if not mental torture,” UN Commission on Human Rights, “Report of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment: mission to China,” E/CN.4/2006/6/Add.6, March 10, 2006, paras 64, 82 (u).

^{xix} Mendelevich V, “Narcology: Drug treatment in Russia,” In *Open Society Institute Briefing on Drug Treatment, HIV, and the Challenge of Reform*, 2006.

^{xx} See “Russian Federation: Inhumane conditions in drug treatment facilities lead to tragedy” in Canadian HIV/AIDS Legal Network, “HIV/AIDS Policy & Law Review,” vol. 12(1), May 2007, pp. 32-33.

^{xxi} Singapore Central Narcotics Bureau, *Annual Bulletin 2007*, pp. 16-19; see also Singapore Central Narcotics Bureau, *Treatment and Rehabilitation Regime and Long-Term Imprisonment for Abusers of Cannabis and Cocaine*, <http://www.cnb.gov.sg/Newsroom/index.asp?name=TmV3c3Jvb2ogLSBQb2xpY3k&year=MjAwNw&page=ODEy&type=Q3VycmVudA>

^{xxii} See Scott Burris et al., ‘Addressing the ‘Risk Environment’ for Injection Drug Users: The Mysterious Case of the Missing Cop’, *The Milbank Quarterly*, vol. 82, no. 1 (2004), pp. 131-35 (reviewing studies); R. Pollini et al., ‘Syringe Possession Arrests are Associated with Receptive Sharing in Two Mexico-US Border Cities’, *Addiction* (2007), vol. 103, pp. 101-108; Joanne Csete ‘Do Not Cross: Policing and HIV Risk Faced by People Who Use Drugs’, Canadian HIV/AIDS Legal Network, 2007, <http://www.aidslaw.ca/publications/interfaces/downloadFile.php?ref=1080>

^{xxiii} Guideline 4, International Guidelines on HIV and Human Rights, http://data.unaids.org/Publications/IRC-pub07/jc1252-interguidelines_en.pdf.

^{xxiv} Aceijas et al ‘Antiretroviral treatment for injecting drug users in developing and transitional countries one year before the end of the ‘Treating 3 million by 2005. Making it happen. The WHO Strategy (x5)’ *Addiction* (2006), vol. 101(9), pp. 1246-1253.

^{xxv} Annemarie Bollerup, M Donoghoe, J Lazarus & SVMatic, ‘Access to HAART for injecting drug users in the WHO European Region 2002-2005’, summary available at http://www.euro.who.int/Document/SHA/ACCESS_TO_HART.pdf.

^{xxvi} The treaty-based drug control system is based on three international drug conventions: the *Single Convention on Narcotic Drugs* (1961) as amended by the 1972 *Protocol Amending the Single Convention on Narcotic Drugs*; the *Convention on Psychotropic Substances* (1971), and the *Convention Against the Illicit Traffic in Narcotic Drugs and Psychotropic Substances* (1988). The 1961 and 1971 treaties require governments “to take all practicable measures” for the prevention of drug abuse, and “for the early identification, treatment, education, after-care, rehabilitation and social reintegration” of people who use drugs.” While all three treaties require governments to criminalize possession other than for medical or scientific purposes, they state that governments may provide measures for “treatment, education, aftercare, rehabilitation and social reintegration”, “either as an alternative to conviction or punishment or in addition to conviction or punishment.”

^{xxvii} INCB Annual Report for 2001, http://www.incb.org/incb/en/annual_report_2001.html, para. 211. See also Commentary on the United Nations Convention Against Illicit Traffic in Narcotic Drugs and Psychotropic Substances (1988), UN Doc. E/CN.7/590 (noting flexibility with respect to criminal penalties, and that “as with the 1961 and 1971 Conventions, paragraph 2 **does not require drug consumption as such to be established as a punishable offence**. Rather, it approaches the issue of non-medical consumption indirectly by referring to the intentional possession, purchase or cultivation of controlled substances for personal consumption (...)”).

^{xxviii} INCB, Report of the International Narcotics Control Board for 2004, New York: 2005, para. 538. Portugal’s 2001 drug law “decriminalized, but did not “legalize” drugs, meaning that while drug possession and drug use are still legally prohibited, violations are considered exclusively administrative and exempt from criminal sanction.

^{xxix} UNODC, World Drug Report 2009, pp. 163ff.

^{xxx} See., e.g., Decision 74/10, Flexibility of Treaty Provisions as Regards Harm Reduction Approaches, prepared by UNDP’s Legal Affairs Section, E/INCB/2002/W.13/SS.5, 30 September 2002.

^{xxxi} See Glenn Greenwald, Drug decriminalization in Portugal: Lessons for creating fair and successful drug policies, CATO Institute, April 2009 http://www.cato.org/pub_display.php?pub_id=10080; Martin Jelsma, Legislative Innovation in Drug Policy, Transnational Institute, Nov. 2009.

^{xxxi} “Drugs and Democracy: Towards and paradigm shift,” Final report of the Latin American Commission on Drugs and Democracy, 2008
http://www.drogasedemocracia.org/Arquivos/declaracao_ingles_site.pdf.

^{xxxii} See “Drug decriminalization in Portugal: Lessons for creating fair and successful drug policies,” CATO Institute, April 2009
http://www.cato.org/pub_display.php?pub_id=10080

^{xxxiii} See, for example, *Roe v. City of New York*, 232 F. Supp.2d 240 (U.S. DCt, SDNY) (barring arrest of needle exchange program participants based on residue in used syringes); *Doe v. Bridgeport Police Department*, 198 F.R.D. 325 (U.S. DCt., SDCT) (same); Los Angeles County Police Order (directing police to refrain from targeting or conducting observation in syringe exchange locations to identify, detain, or arrest persons for narcotics-related offenses).

^{xxxiv} In Vancouver, Canada, for example, drug users are covered by a provision of the federal Controlled Drugs and Substances Act that exempts any person or class of persons from the application of the Act if, in the opinion of the Minister of Health, “the exemption is necessary for a medical or scientific purpose or is otherwise in the public interest.” Controlled Drugs and Substances Act, Section 56. For further information on safe injection sites, see Richard Elliott et al., *Establishing Safe Injection Facilities in Canada: Legal and Ethical Issues* (Canadian HIV/AIDS Legal Network, 2002), [online]

<http://www.aidslaw.ca/Maincontent/issues/druglaws/safeinjectionfacilities/safeinjectionfacilities.pdf>; and City of Vancouver, “Supervised Injection Sites (SISs): Frequently Asked Questions,” [online] www.city.vancouver.bc.ca/fourpillars (retrieved January 4, 2006).

^{xxxv} See Harm Reduction Policy and Practice Global State of Harm Reduction 2008, International Harm Reduction Association,
<http://www.ihra.net/GlobalStateofHarmReduction>.