

The War on Drugs and HIV/AIDS

How the
Criminalization of
Drug Use Fuels the
Global Pandemic



**REPORT OF THE
GLOBAL COMMISSION
ON DRUG POLICY**



Upper Left: Protesters at London's Russian Embassy demand the introduction of opiate substitution therapy and the scale-up of syringe access programs.

Photo: International Network of People who Use Drugs
www.inpud.net

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REPORT OF THE GLOBAL COMMISSION ON DRUG POLICY



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The global war on drugs is driving the HIV/AIDS pandemic among people who use drugs and their sexual partners. Throughout the world, research has consistently shown that repressive drug law enforcement practices force drug users away from public health services and into hidden environments where HIV risk becomes markedly elevated. Mass incarceration of non-violent drug offenders also plays a major role in increasing HIV risk. This is a critical public health issue in many countries, including the United States, where as many as 25 percent of Americans infected with HIV may pass through correctional facilities annually, and where disproportionate incarceration rates are among the key reasons for markedly higher HIV rates among African Americans.

Aggressive law enforcement practices targeting drug users have also been proven to create barriers to HIV treatment. Despite the evidence that treatment of HIV infection dramatically reduces the risk of HIV transmission by infected individuals, the public health implications of HIV treatment disruptions resulting from drug law enforcement tactics have not been appropriately recognized as a major impediment to efforts to control the global HIV/AIDS pandemic.

The war on drugs has also led to a policy distortion whereby evidence-based addiction treatment and public health measures have been downplayed or ignored. While this is a common problem internationally, a number of specific countries, including the US, Russia and Thailand, ignore scientific evidence and World Health Organization recommendations and resist the implementation of evidence-based HIV prevention programs – with devastating consequences. In Russia, for example, approximately one in one hundred adults is now infected with HIV.

In contrast, countries that have adopted evidence-based addiction treatment and public health measures have seen their HIV epidemics among people who use drugs – as well as rates of injecting drug use – dramatically decline. Clear consensus guidelines exist for achieving this success, but HIV prevention tools have been under-utilized while harmful drug war policies have been slow to change.

This may be a result of the mistaken assumption that drug seizures, arrests, criminal convictions and other commonly reported indices of drug law enforcement “success” have been effective overall in reducing illegal drug availability.

However, data from the United Nations Office on Drugs and Crime demonstrate that the worldwide supply of illicit opiates, such as heroin, has increased by more than 380 percent in recent decades, from 1000 metric tons in 1980 to more than 4800 metric tons in 2010. This increase coincided with a 79 percent decrease in the price of heroin in Europe between 1990 and 2009.

Similar evidence of the drug war’s failure to control drug supply is apparent when US drug surveillance data are scrutinized. For instance, despite a greater than 600 percent increase in the US federal anti-drug budget since the early 1980s, the price of heroin in the US has decreased by approximately 80 percent during this period, and heroin purity has increased by more than 900 percent. A similar pattern of falling drug prices and increasing drug potency is seen in US drug surveillance data for other commonly used drugs, including cocaine and cannabis.

As was the case with the US prohibition of alcohol in the 1920s, the global prohibition of drugs now fuels drug market violence around the world. For instance, it is estimated that more than 50,000 individuals have been killed since a 2006 military escalation against drug cartels by Mexican government forces. While supporters of aggressive drug law enforcement strategies might assume that this degree of bloodshed would disrupt the drug market’s ability to produce and distribute illegal drugs, recent estimates suggest that Mexican heroin production has increased by more than 340 percent since 2004.

With the HIV epidemic growing in regions and countries where it is largely driven by injection drug use, and with recent evidence that infections related to injection drug use are now increasing in other regions, including sub-Saharan Africa, the time for leadership is now. Unfortunately, national and United Nations public health agencies have been sidelined. While the war on drugs has been fueling the HIV epidemic in many regions, other law enforcement bodies and UN agencies have been actively pursuing an aggressive drug law enforcement agenda at the expense of public health. Any sober assessment of the impacts of the war on drugs would conclude that many national and international organizations tasked with reducing the drug problem have actually contributed to a worsening of community health and safety. This must change.

SUMMARY OF THE RECOMMENDATIONS FROM THIS REPORT*

The following action must be taken by national leaders and the United Nations Secretary General, as well as the United Nations Office on Drugs and Crime, UNAIDS and the Commission on Narcotic Drugs:

1. Acknowledge and address the causal links between the war on drugs and the spread of HIV/AIDS, drug market violence and other health (e.g., hepatitis C) and social harms.
2. Respond to the fact that HIV risk behavior resulting from repressive drug control policies and under-funding of evidence-based approaches is the main issue driving the HIV epidemic in many regions of the world.
3. Push national governments to halt the practice of arresting and imprisoning people who use drugs but do no harm to others.
4. Replace ineffective measures focused on the criminalization and punishment of people who use drugs with evidence-based and rights-affirming interventions proven to meaningfully reduce the negative individual and community consequences of drug use.
5. Countries that under-utilize proven public health measures should immediately scale up evidence-based strategies to reduce HIV infection and protect the health of persons who use drugs, including sterile syringe distribution and other safer injecting programs. Failure to take these steps is criminal.
6. The public and private sectors should invest in an easily accessible range of evidence-based options for the treatment and care for drug dependence, including substitution and heroin-assisted treatment. These strategies reduce disease and death, and also limit the size and harmful consequences of drug markets by reducing the overall demand for drugs.
7. All authorities - from the municipal to international levels - must recognize the clear failure of the war on drugs to meaningfully reduce drug supply and, in doing so, move away from conventional measures of drug law enforcement "success" (e.g., arrests, seizures, convictions), which do not translate into positive effects in communities.
8. Measure drug policy success by indicators that have real meaning in communities, such as reduced rates of transmission of HIV and other infectious diseases (e.g., hepatitis C), fewer overdose deaths, reduced drug market violence, fewer individuals incarcerated and lowered rates of problematic substance use.
9. Call for public health bodies within the United Nations system to lead the response to drug use and related harms and to promote evidence-based responses. Other bodies, including the International Narcotics Control Board, should be subjected to independent external review to ensure the policies they promote do not worsen community health and safety.
10. Act urgently: The war on drugs has failed, and millions of new HIV infections and AIDS deaths can be averted if action is taken now.

* The recommendations from the Global Commission on Drug Policy's 2011 "War on Drugs" report are summarized on the inside back cover of this report.

The War on Drugs and the HIV/AIDS Pandemic

The global war on drugs is driving the HIV/AIDS pandemic among people who use drugs and their sexual partners. Today, there are an estimated 33 million people worldwide living with the human immunodeficiency virus (HIV), and injecting drug use accounts for approximately one-third of new HIV infections occurring outside sub-Saharan Africa.¹ While the annual number of new infections has been falling since the late 1990s, HIV incidence increased by more than 25 percent in seven countries over this time span, largely as a result of HIV transmission related to intravenous drug use.¹ Five of these countries are in Eastern Europe and Central Asia, where the war on drugs is being aggressively fought and, as a result, the number of people living with HIV in this part of the world has almost tripled since 2000.¹

Globally, an estimated 16 million people inject illegal drugs, of whom about 3 million, or nearly one in five, are living with HIV.² The average HIV prevalence among drug injectors in China, the United States of America and the Russian Federation – the three countries with the largest populations of injection drug users – is estimated to be 12 percent, 16 percent and 37 percent, respectively.² While these statistics point to a serious public health emergency, they do not expose the causal role that punitive drug law enforcement measures have played in driving the HIV epidemic within this population.³ As described below, treating drug use as a criminal offense fuels the HIV epidemic via several mechanisms.

HOW THE DRUG WAR FUELS THE HIV PANDEMIC:

- **Fear of arrest drives persons who use drugs underground, away from HIV testing and HIV prevention services and into high risk environments.**
- **Restrictions on provision of sterile syringes to drug users result in increased syringe sharing.**
- **Prohibitions or restrictions on opioid substitution therapy and other evidence-based treatment result in untreated addiction and avoidable HIV risk behavior.**
- **Conditions and lack of HIV prevention measures in prison lead to HIV outbreaks among incarcerated drug users.**
- **Disruptions of HIV antiretroviral therapy result in elevated HIV viral load and subsequent HIV transmission and increased antiretroviral resistance.**
- **Limited public funds are wasted on harmful and ineffective drug law enforcement efforts instead of being invested in proven HIV prevention strategies.**

Upper Right: US marine patrols a poppy field in Afghanistan.
Photo: United States Marine Corps (CC BY-NC 2.0)

Far Upper Right: An injecting drug user is injected with heroin, locally known as brown sugar, by his companion by a roadside in the eastern Indian city of Siliguri.
Photo: Reuters / Rupak De Chowdhuri



Fear of Police and Stigma Drive HIV Risk Behavior

Aggressive drug law enforcement practices aimed at suppressing the drug market drive drug-addicted individuals away from public health services and into hidden environments where HIV risk becomes markedly elevated.⁴ While police violence and torture of drug users have been widely reported,⁵ police harassment, confiscation of clean syringes and arrest for possession of syringes are also common, and all of these practices have repeatedly been shown to increase the sharing of used syringes and other risky drug injection practices.^{6,7}

Drug law enforcement's contribution to HIV risk behavior can and should be avoided. A study published in the British medical journal *The Lancet* that explored how confrontations with police promote HIV risk behavior estimated that up to 19 percent of HIV infections among drug-addicted persons in Odessa, Ukraine could be avoided if abuse of drug users by police was halted.⁸

In many settings, harsh drug laws have been shown to increase HIV risk behavior and push users away from public health services. The following words from a young woman in Moscow describe the fear caused by aggressive drug law enforcement:

“Fear. Fear. This is the very main reason. And not only fear of being caught, but fear that you will be caught, and you won’t be able to get a fix. So on top of being pressured and robbed [by police], there’s the risk you’ll also end up being sick. And that’s why you’ll use whatever syringe is available right then and there.”



Inmates sit in a recreation room where they are housed due to overcrowding at the California Institution for Men state prison in Chino, California, June 3, 2011. The Supreme Court has ordered California to release more than 30,000 inmates over the next two years or take other steps to ease overcrowding in its prisons to prevent "needless suffering and death." California's 33 adult prisons were designed to hold about 80,000 inmates and now have about 145,000. The US has more than 2 million people in state and local prisons. It has long had the highest incarceration rate in the world.

Reuters / Lucy Nicholson

Mass Incarceration Fuels HIV Transmission

Although most HIV transmission among drug users occurs in their communities, the mass incarceration of non-violent drug law offenders is also a significant factor in the epidemic. This is a critical public health issue in many countries, including the United States, where HIV prevalence and AIDS cases behind bars are many times higher than among the general population^{9,10} and where as many as one-quarter of all HIV-infected Americans are estimated to pass through correctional facilities annually.¹¹ Statistics for the US are consistent with global trends, with twenty low- to middle-income countries reporting HIV prevalence of greater than 10 percent among prison inmates.¹²

High rates of incarceration among drug users with or at risk of HIV infection are a matter of deep concern, given that incarceration has been associated with syringe sharing, unprotected sex and HIV outbreaks in many places around the world. Incarceration has been identified as a risk factor for acquiring HIV infection in countries of western and southern Europe, Russia, Canada, Brazil, Iran and Thailand.¹³ Research has also shown that the sharing of used syringes is the primary reason for the spread of HIV in prison settings, and public health investigations using viral genetic techniques have proven that HIV outbreaks

have emerged as a result of syringe sharing among inmates.¹³⁻¹⁵ As described below, incarceration also drives risk of HIV infection and disease by interrupting antiretroviral HIV treatment.

Research conducted in the United States, where ethnic minorities are many times more likely than whites to be incarcerated for drug-related offenses, has found that disproportionate incarceration rates are one of the key reasons for the markedly elevated rates of HIV infection among African Americans.^{16,17} This is an urgent public health concern, as African Americans represent just 12 percent of the US population but, in recent years, have accounted for more than 50 percent of the nation's new HIV infections.¹⁸

The global emphasis on drug law enforcement has also led to mass incarceration of drug users in compulsory "drug detention centers," particularly in places where HIV is rapidly spreading among this population.¹⁹ Although these centers vary in their design and operation, reports consistently indicate that these facilities fail to offer evidence-based addiction treatment or HIV care. Documented cases of forced labor, torture and other human rights abuses are widespread in these settings.²⁰ Despite recent criticism by a range of health and human rights organizations, as well as the United Nations and US government, compulsory drug detention centers continue to operate, especially in China and Southeast Asia.^{21,22}

Drug Law Enforcement Creates Barriers to Antiretroviral Therapy, Thereby Promoting HIV Transmission

In addition to promoting the sharing of syringes and other HIV risk behavior, punitive drug law enforcement measures create barriers to HIV testing and treatment. There are several ways the criminalization of drug use may hinder or prevent access to essential treatment for drug users infected with HIV. These barriers to treatment include stigma and discrimination within healthcare settings, refusal of services, breaches of confidentiality, requirements to be drug-free as a condition of treatment, and the use of registries that lead to denial of such basic rights as employment and child custody.^{19,23} As a result, research has repeatedly shown that drug users have lower rates of antiretroviral therapy use and higher HIV/AIDS death rates.²⁴

Punitive drug law enforcement policies and practices also have broader implications for public health. Specifically, antiretroviral therapy is known to reduce the amount of human immunodeficiency virus circulating in the blood and sexual fluids, and recent clinical trials have proven that this effect also reduces rates of HIV transmission. As a result, many international agencies and national HIV programs have now shifted their focus to HIV “treatment as prevention” as a central HIV/AIDS strategy.²⁵⁻²⁸ This shift has major implications for the design of the global HIV/AIDS response since it further emphasizes the public health impact of providing all segments of the population, including persons who inject drugs, with access to HIV treatment.

Medicine for patients is lined up for distribution at the HIV/AIDS ward of Beijing YouAn Hospital December 1, 2011. The number of new HIV/AIDS cases in China is soaring, state media said, citing health officials, with rates of infections among college students and older men rising. The Chinese Center for Disease Control and Prevention issued figures showing 48,000 new cases in China in 2011, the official Xinhua news agency said. China’s government was initially slow to acknowledge the problem of HIV/AIDS in the 1990s.
Reuters / David Gray

However, numerous studies have demonstrated that coercive drug law enforcement measures and the frequent incarceration of people who use drugs hinder them from seeking HIV testing and treatment, and contribute to the interruption of HIV treatment once it has begun.²⁹ For example, a recent Canadian study showed that the greater the number of times an HIV-infected individual was incarcerated, the less likely that person was to adhere to antiretroviral therapy.³⁰ Similarly, a Baltimore study of HIV-infected patients found that even brief periods of incarceration were associated with a two-fold risk of syringe sharing and a greater than seven-fold risk of virological failure.³¹ The fact that drug law enforcement measures often disrupt HIV treatment efforts, promoting HIV drug resistance and increasing risk of HIV transmission, has yet to be appropriately addressed in national and international HIV prevention strategies.^{27,28} In fact, “treatment as prevention” and new prevention strategies such as scaled-up use of pre-exposure prophylaxis with antiretroviral medicines are rarely even considered or discussed by policymakers as responses to HIV among people who inject drugs.



Where Public Health Approaches Are Ignored, the HIV Epidemic Is Out of Control

In addition to increased HIV risk behavior and barriers to HIV treatment, the war on drugs has also led to the distortion of public policy, whereby evidence-based addiction treatment and public health interventions have been ignored or downplayed. In 2008, the Executive Director of the United Nations Office on Drugs and Crime acknowledged this reality, reflecting on the prior decade of drug control:

“Public health, which is clearly the first principle of drug control, also needs a lot of resources. Yet the funds were in many cases drawn away into public security and the law enforcement that underpins it. The consequence was that public health was displaced into the background, more honored in lip service and rhetoric, but less in actual practice.”

The emphasis on drug law enforcement has created legal barriers to evidence-based HIV prevention measures, such as the provision of clean syringes, and evidence-based addiction treatment methods, such as methadone maintenance therapy. These public health approaches have been proven to reduce HIV risk and are widely endorsed by major international medical and public health bodies.^{32,33} Methadone, for instance, is on the World Health Organization’s Model List of Essential Medicines, and various scientific reviews of the effectiveness of sterile syringe provision in reducing HIV risk have led the United Nations to strongly recommend sterile syringe provision.³⁴

Nevertheless, public health assessments have shown extremely low rates of coverage of proven interventions, including in those settings where they are most urgently needed.²⁴ For example, contrary to the advice of many scientific bodies and the recommendations of the World Health Organization, a number of countries, including the US and Russia, have resisted the implementation of evidence-based HIV prevention programs. In the US, Congress has recently reinstated the ban on federal funding of syringe exchange programs both domestically and abroad, just two years after lifting what had been a 21-year ban. Access to sterile syringes is limited in various other countries with high HIV rates among injecting drug users.

Remarkably, despite the extensive body of clinical research proving the benefits of methadone maintenance therapy in reducing the individual and community harms of heroin use as well as HIV risk,^{35,36} the use of methadone remains limited in many countries and is illegal in Russia. Similarly, in the Central Asian republics and other countries of the former Soviet bloc, methadone programs tend to be “perpetual pilot programs” created in some cases in response to donor pressure but never brought to anything approaching the scale that would meet existing demand.

A recent UN report describing the HIV prevention situation in Poland, which was critical of the nation’s anti-drug laws, noted that “in the context of HIV, there has been a gap in funding and work on HIV prevention, which in turn impacts the availability of prevention services including harm reduction measures.”³⁷ Settings where HIV prevention measures have been curtailed as a result of economic concerns have been particularly vulnerable to increases in HIV risk among injection drug users. For instance, a greater than 10-fold increase in newly diagnosed HIV infections among injecting drug users has recently been reported from Greece during the first seven months of 2011.³⁸ Although the Russian Federation was recently investing close to US\$800 million annually in HIV-related initiatives, less than one percent of this amount was targeted toward prevention for people who use drugs, among whom the Russian epidemic is concentrated.³⁹ As a result of the lack of evidence-based addiction treatment and HIV prevention measures, about one in one hundred Russian adults is now infected with HIV (Figure 1).

In spite of evidence of a long and expanding problem of heroin injection in many coastal areas of sub-Saharan Africa, especially the East African coast,² a small methadone program in Mauritius and one begun in February 2010 in Tanzania are virtually the only public sector opioid maintenance therapy programs south of the Sahara. Similarly, methadone remains effectively inaccessible in many parts of South and East Asia even where opiate injection is known to occur on a significant scale.

Thailand is also an important case study, as the country is often credited with successfully reducing HIV among sex workers and their clients by distributing and promoting the use of condoms, along with other evidence-based measures. Among female commercial sex workers in Thailand, the estimated HIV prevalence has declined from a peak of more than 40 percent in 1995 to less than 5 percent in recent years. At the same time, however, Thailand has

FIGURE 1.
Estimated number of HIV-infected individuals in the Russian Federation

Source: Joint United Nations Programme on HIV/AIDS

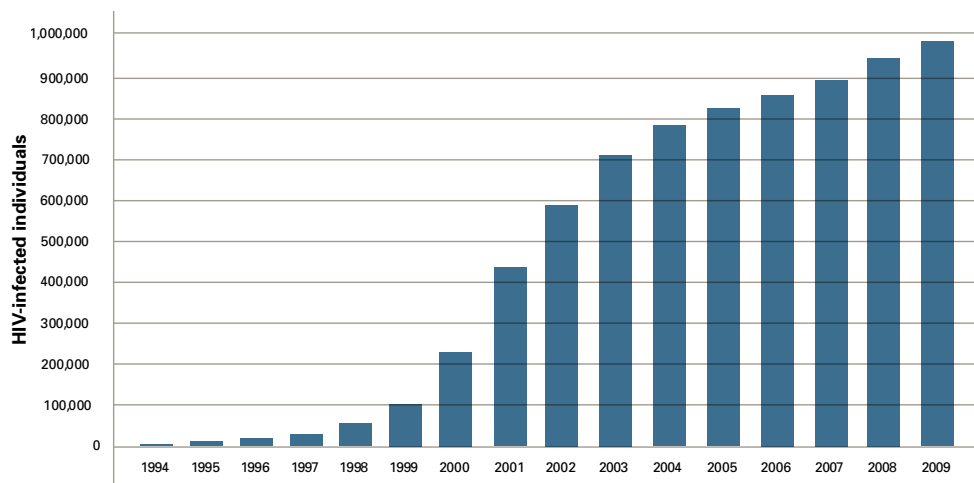
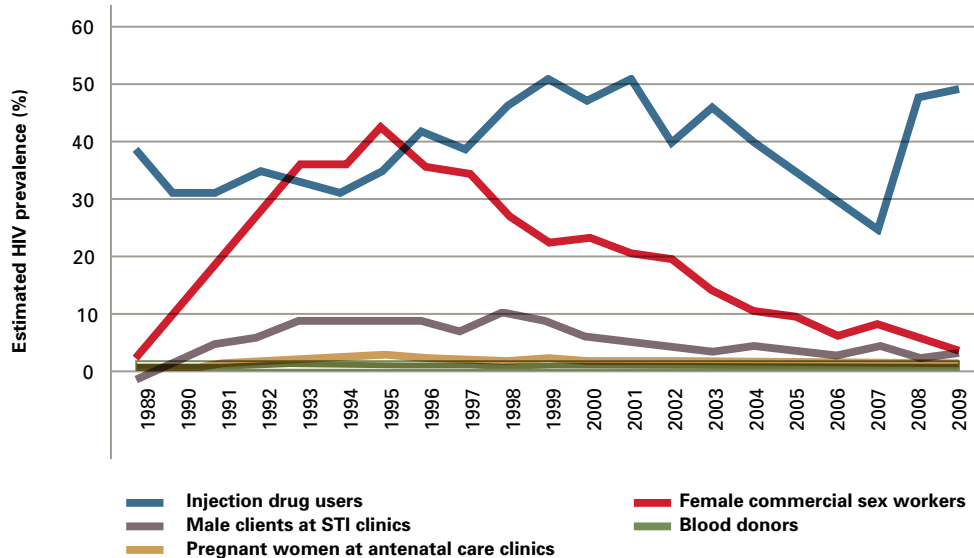


FIGURE 2.
Estimated HIV prevalence among different risk groups in Thailand

Source: Thailand Bureau of Epidemiology, HIV Total Sentinel Surveillance. Ministry of Public Health (2011)



maintained its longstanding war-on-drugs approach to illicit drug use, with drug users being considered “security threats.” The 2003 crackdown on suspected drug dealers resulted in the heinous extrajudicial killing of more than 2,500 persons.⁴⁰ The crackdown and a continued repression made it less likely that people who use drugs would seek health services, including HIV treatment. Not surprisingly, therefore, while HIV prevalence among sex workers has declined dramatically, HIV rates among Thai drug users have remained persistently high, with estimated HIV prevalence approaching 50 percent in recent years (Figure 2).

Even when different regions within countries are compared, higher HIV rates are clearly evident in areas with the most intense drug law enforcement. For instance, a study of the 96 largest US metropolitan areas found that measures of anti-drug “legal repressiveness” were associated with higher HIV prevalence among injectors and concluded: “This may be because fear of arrest and/or punishment leads drug injectors to avoid using syringe exchanges, or to inject hurriedly or to inject in shooting galleries or other multiperson injection settings to escape detection.”⁴¹

Where Addiction is Treated as a Health Issue, the Fight Against HIV is Being Won

The experience in Russia, Thailand, the US and other countries where the war on drugs has been aggressively waged can be contrasted with countries that have adopted evidence-based addiction treatment and public health measures to address the HIV epidemic. In the latter countries, including a number of western European countries and Australia, newly diagnosed HIV infections have been nearly eliminated among people who use drugs, just as vertical transmission of HIV has been eliminated in countries where broad access to prevention of mother-to-child transmission of the virus is available.

Indeed, as early as 1997, a global survey found that in 52 cities without syringe exchange, HIV prevalence increased by approximately 6 percent per year, whereas prevalence decreased by approximately 6 percent per year in the 29 cities with syringe exchange programs.⁴² Since that time, similar results have consistently been reported from around the globe.³² For example, in Tallinn, Estonia, a country with one of the highest per capita HIV rates in Europe, a decrease in HIV infection among new injectors, from 34 percent to 16 percent, coincided with an increase in the number of syringes exchanged, from 230,000 in 2005 to 770,000 in 2009.⁴³ Similarly, in Portugal in 2001, the government decriminalized the use and possession of a modest quantity of illegal drugs for personal use, so as to focus on drug addiction as a public health issue. As a result, between 2000 and 2008, the number of new cases of HIV decreased from 907 to 267, while the number of cases of AIDS dropped from 506 to 108 among people there who inject drugs.⁴⁴

The contents of a syringe exchange kit.

Photo: Todd Huffman (CC BY 2.0)

In Switzerland, the government responded to the burgeoning HIV epidemic among injection drug users in the 1980s by implementing innovative policies that provided clean syringes, supervised injecting facilities, easily accessible methadone therapy, heroin prescription and antiretroviral treatment.⁴⁵ This strategy has led to a marked reduction in the number of new HIV infections linked to drug injection, from an estimated 68 percent in 1985 to about 15 percent in 1997 and about 5 percent in 2009.⁴⁵ Likewise, in British Columbia, Canada, the response to the explosive HIV epidemic that emerged among injection drug users in the mid-1990s has involved antiretroviral therapy, opioid substitution (including heroin prescription), syringe distribution and medically supervised injecting facilities, with resulting declines in HIV incidence and AIDS deaths among intravenous drug users there (Figure 3).

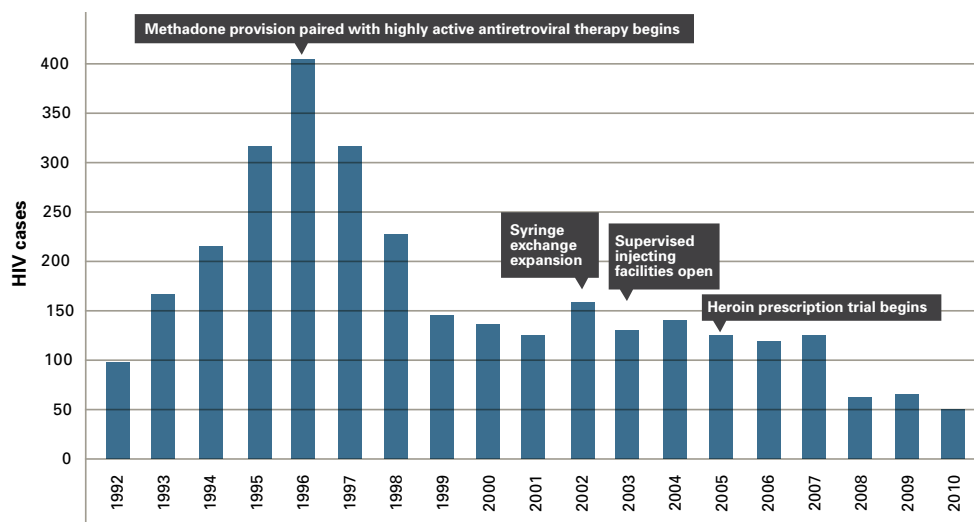
While modest gains have been made with respect to treatment of opioid dependence, methamphetamine and other stimulants dominate illicit drug use in many parts of the world, and scientifically sound treatment options for them are more limited.¹⁹ The Commission sees an urgent need for more research on maintenance and other therapeutic approaches to managing stimulant use, including as a component of HIV prevention programs.



FIGURE 3.

Decline in new HIV cases attributable to drug injecting in British Columbia coinciding with public health interventions

Source: BC Centre for Disease Control and BC Centre for Excellence in HIV/AIDS



HIV/AIDS Has Spread Because the War on Drugs Has Not Reduced Drug Supply

Evidence that the war on drugs has fueled the HIV epidemic is irrefutable, and yet policy has been remarkably slow to change. This may largely be a result of the mistaken assumption that drug seizures, arrests, convictions and other commonly reported indices of drug law enforcement “success” have been effective at reducing drug supply. Indeed, stressing the importance of supply reduction tactics, the 2012 US National Drug Control Strategy concludes: “Reductions in supply are often closely tied to reductions in drug use and its consequences.”⁴⁶ However, the assumptions about the benefits of drug law enforcement, implied each time the fruits of the latest “drug bust” are displayed before the public, have not been critically evaluated.

Specifically, if the kind of intensive drug law enforcement that has been practiced under the global war on drugs was achieving its stated objectives of meaningfully reducing drug supply, one would expect that increasing anti-drug expenditures would coincide with higher drug prices, decreased drug potency and fewer drugs available overall. However, evidence from around the world indicates that this has not been the case.

According to data from the United Nations Office on Drugs and Crime, for example, the worldwide supply of illicit opiates such as heroin and opium has increased dramatically over the past 30 years. During this period,

the global illicit opiate supply increased by more than 380 percent overall, from 1000 metric tons in 1980 to more than 4800 metric tons in 2010 (Figure 4).⁴⁷ This increase, the bulk of which occurred in Afghanistan, contributed to a greater than 75 percent decrease in the price of heroin in Europe between 1990 and 2009 (Figure 5).

Similar evidence of the drug war’s failure is provided by US drug surveillance data. For example, from 1981 to 2011, the budget of the US Office of National Drug Control Policy increased by more than 600 percent (inflation-adjusted). However, despite increasing annual multibillion dollar investments in drug control, US government data suggest an approximate inflation- and purity-adjusted decrease in heroin price of 80 percent, and a greater than 900 percent increase in heroin purity between 1981 and 2002, clearly indicating that expenditures on interventions to reduce the supply of heroin into the United States were unsuccessful (Figure 6).*

While the links between the war on drugs and HIV/AIDS warrant a focus on heroin, similar patterns emerge when anti-drug spending and indices of availability for other drugs are examined. For instance, through a variety of initiatives, the United States has directed considerable

* The reporting of the budget of the US Office of National Drug Control Policy was altered between 2003 and 2010, limiting comparative analysis between the budgeting during this and other periods (see Figure 6).

FIGURE 4.
Estimated global production of illicit opiates

Source: United Nations World Drug Report 2011, United Nations Office on Drugs and Crime

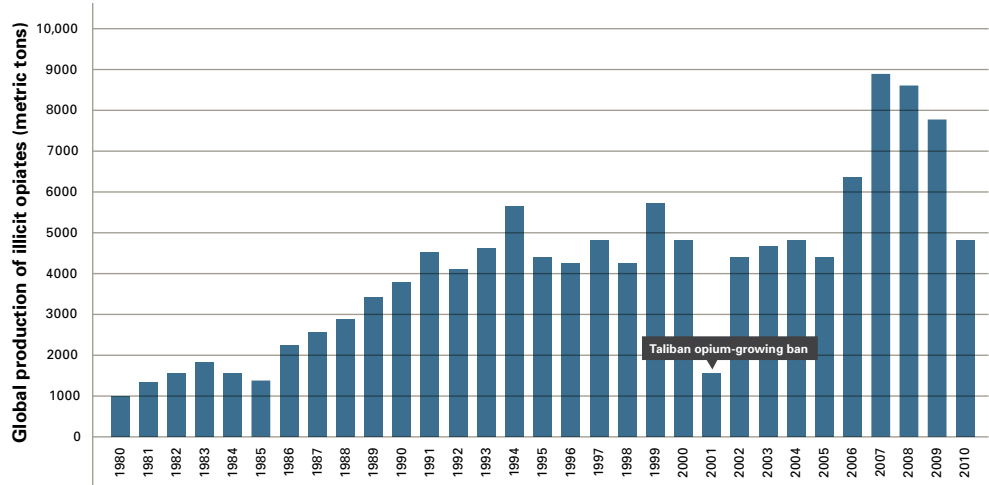


FIGURE 5.
Average estimated heroin prices in Europe

Note: Heroin prices are inflation-adjusted. All prices expressed in 2011 USD.
 Source: United Nations Office on Drugs and Crime

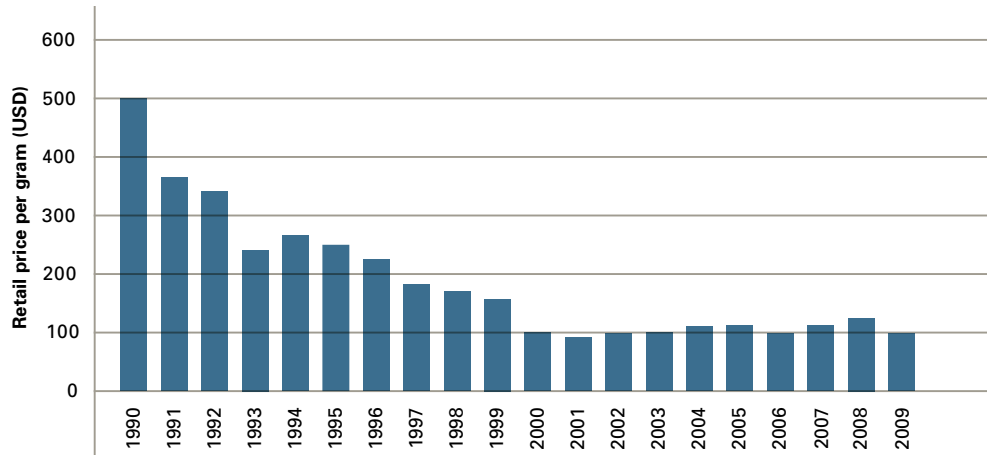
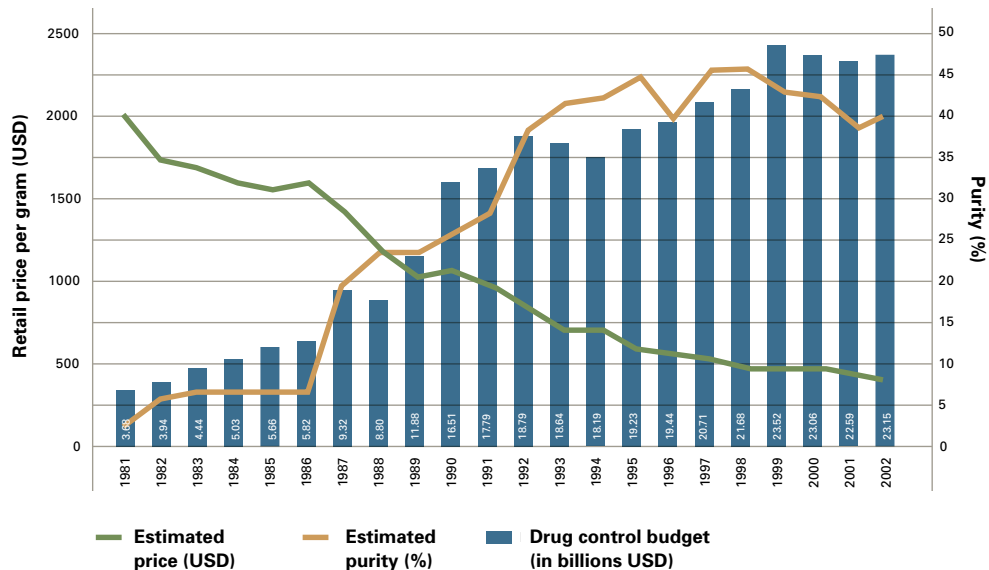


FIGURE 6.
Change in estimated heroin price and purity in the context of the increasing annual drug control budget in the United States

Note: Data are truncated at 2002 because US federal drug control budget was not consistently reported after this date. Heroin prices are purity- and inflation-adjusted and spending is inflation-adjusted. All prices expressed in 2011 USD.
 Source: US Office of National Drug Control Policy, Drug Enforcement Agency (DEA) STRIDE Surveillance System, DEA Heroin Domestic Monitor Program



(Continued from page 11)

resources toward disrupting the cocaine trade. Plan Colombia, for example, was a multibillion dollar investment in the eradication of coca crops in Colombia through aerial and manual eradication, military training and support, and other means. Nevertheless, despite steady increases in the US budget for international supply reduction and counter-narcotics activities, the purity of cocaine has remained persistently high, while the purity- and inflation-adjusted price of cocaine in the US has concurrently dropped by more than 60 percent during this period (Figure 7). These long-term trends suggest that the overall supply of cocaine has overwhelmed law enforcement efforts and highlight how recent US government reports of diminishing cocaine supply to the US must be interpreted with a great deal of skepticism.⁴⁸

When cannabis, the drug that has been the central focus of the US government's decades-long war on drugs, is considered, the results have been the same. Specifically, the potency- and inflation-adjusted price of cannabis in the US has declined by 33 percent while its potency has increased by 145 percent since 1990. In fact, the

US National Institute on Drug Abuse has concluded that over the last 30 years of cannabis prohibition, the drug has remained "almost universally available to American 12th graders," with between 80 percent and 90 percent consistently reporting that the drug is "very easy" or "fairly easy" to obtain.⁴⁹

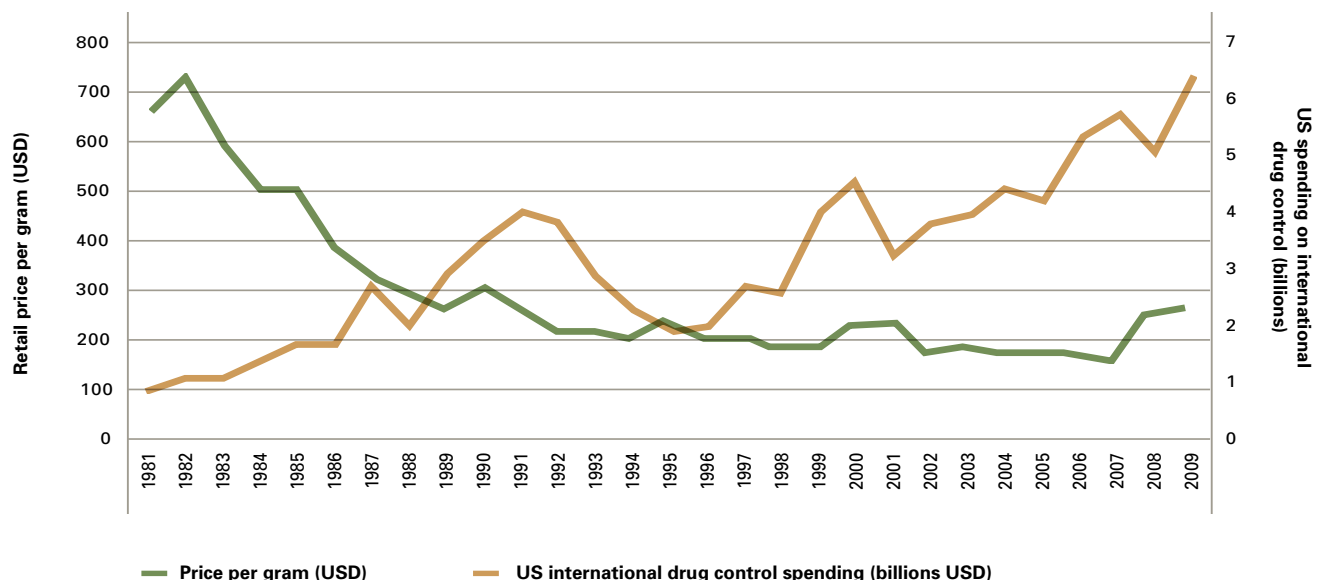
Recent United Nations Office on Drugs and Crime estimates have concluded that production of amphetamine-type stimulants has risen dramatically in the last decade, so much so that this class of illegal drug is now used more frequently than any but marijuana. However, aggressive drug law enforcement strategies targeting users of new synthetic drugs have the same negative public health effects.

Taken together, these indicators clearly suggest that the overall drug supply (as evidenced by various indicators of increasing production, declining prices and increasing potency) has been largely unimpeded by the multibillion dollar investments that have gone into trying to disrupt supply through costly policing, arrests and interdiction efforts.

FIGURE 7.

Dramatic decline in domestic cocaine prices despite increasing spending for overseas drug suppression efforts by the United States

Note: Cocaine prices are purity- and inflation-adjusted and spending is inflation-adjusted. All prices expressed in 2011 USD.
Source: US Office of National Drug Control Policy



The Drug War Spreads Violence in Addition to HIV

Overwhelming evidence now clearly demonstrates that, analogous to the case of alcohol prohibition in the United States early in the 20th century, prohibition of drugs has contributed to increased levels of drug-related mortality and drug market violence. Research from Switzerland, for example, has demonstrated that mortality levels among Swiss heroin users decreased as a result of opioid substitution treatment but increased following periods of intensified street-level drug law enforcement.⁵⁰ Similarly, according to a recent systematic review of published research investigating the association between drug law enforcement and drug-related violence, virtually all studies on the subject have concluded that increased levels of enforcement activity have been associated with increased drug market violence.⁵¹ This study concluded that drug arrests and



Reporters stand next to a display of guns, bundles of marijuana and cocaine seized from the Sinaloa cartel during “Operation Pipeline Express” at a news conference in Phoenix, Arizona.
Photo: Reuters / Joshua Lott

other drug law enforcement strategies that remove individuals from the lucrative drug market contribute to violence by having the “perverse effect of creating new financial opportunities,” resulting in fights over market share.

While drug market violence can be viewed as a natural consequence of drug prohibition in nearly all countries, certain drug-producing regions have been particularly hard hit. In Mexico, for example, following a 2006 government-initiated crackdown on drug cartels, drug-related violence involving the Mexican military, police and cartel factions has become entrenched on a massive scale. While accurate numbers are difficult, if not impossible, to obtain, the most widely used estimates suggest that the total number of deaths attributable to drug market violence since 2006 is in excess of 50,000 (Figure 8).⁵² Other estimates suggest that a further 10,000 individuals are missing and more than 1.5 million have been displaced by fighting related to drug control.

While supporters of aggressive drug law enforcement strategies might assume that this degree of bloodshed would actually disrupt the ability of drug cartels to produce and distribute drugs, this has clearly not been the case, with recent estimates suggesting that Mexican heroin production has increased by more than 340 percent since 2004 (Figure 9).

“Crack” cocaine markets also deserve specific mention, in light of the related public health issues and the known connections between anti-crack law enforcement efforts and drug market violence.⁵³ Specifically, in the mid-1990s, the link between crack use and HIV infection was described in a study of US inner city neighborhoods which found that crack smokers were twice as likely as non-smokers to be infected with HIV.⁵⁴ These results have since been confirmed by other research, including a recent Canadian study showing that rising rates of crack cocaine use predicted elevated HIV infection rates.⁵⁵ Given that intensive enforcement of anti-crack drug laws has resulted in increased drug market violence yet has failed to limit the availability of the drug, treating crack cocaine use as a public health concern, rather than a criminal justice issue, should be a priority.⁵³

FIGURE 8.
Estimated drug-related homicides in Mexico before and after the government crackdown on drug cartels

Source: Government and news report estimates as reported in Transborder Institute, "Drug Violence in Mexico" and WM Consulting, "Mexico Total Dead, 2011"

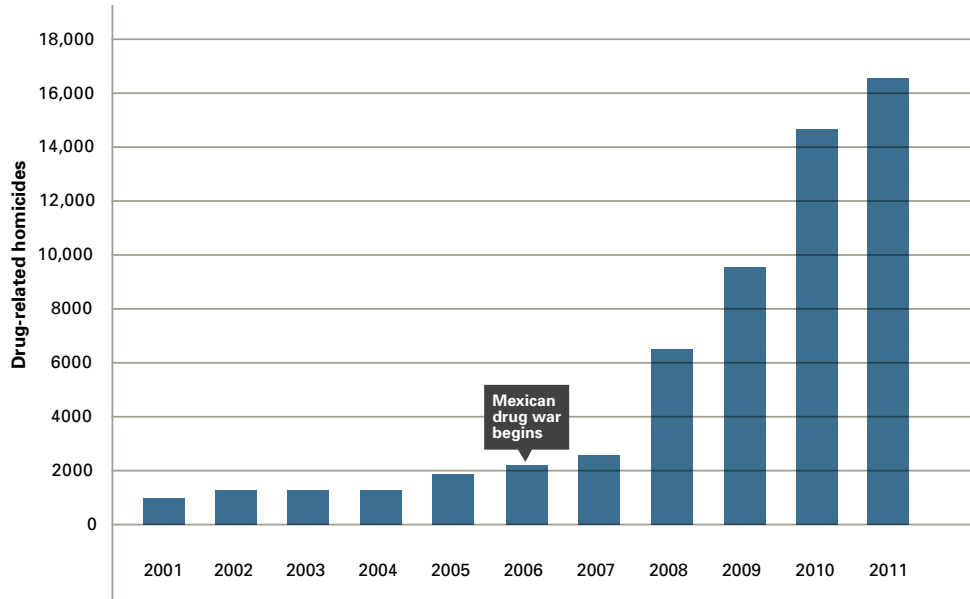
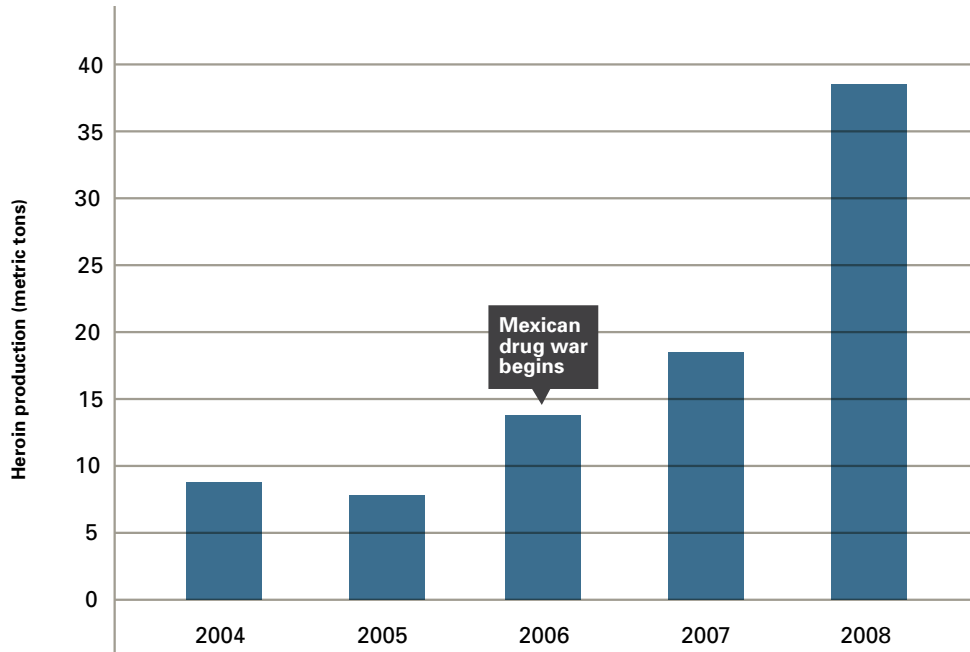


FIGURE 9.
Heroin production in Mexico

Source: US Department of Justice, National Drug Intelligence Center, National Drug Threat Assessment 2010





In many parts of the world, the constant threat of police arrest, violence and incarceration at harm reduction drop-in centers, methadone clinics and other places where people who use drugs receive services minimizes the impact of these services.

Photo: Citizen News Service (CC BY 3.0)

Public Health Approaches Can Reduce Rates of Drug Use

The Global Commission on Drug Policy's previous report called for a public health approach to address the harms of drug use and drug prohibition. Unfortunately, the report was met with criticism from the US White House, with an Office of National Drug Control Policy spokesperson widely quoted as saying: "Drug addiction is a disease that can be successfully prevented and treated. Making drugs more available, as this report suggests, will make it harder to keep our communities healthy and safe."⁵⁶ This comment implies an inaccurate interpretation of our first report and is problematic for two reasons. First, US drug strategy remains focused on a criminal justice approach to drug use, with overwhelming federal and state drug control budgets dedicated to drug law enforcement and enforcement-based prevention programs and interdiction rather than public health measures or the treatment of addiction. Second, the assumption that a public health approach to drug use will lead to increased rates of drug use or other adverse impacts on communities is not consistent with empirical evidence.

A study completed as part of the World Health Organization's World Mental Health Survey Initiative that looked at patterns of drug law enforcement and rates of drug use internationally concluded: "Globally, drug use is not distributed evenly and is not simply related to drug policy, since countries with stringent

user-level illegal drug policies did not have lower levels of use than countries with liberal ones."⁵⁷ National studies of drug use patterns further support these trends. For example, a 10-year study of drug arrests from 93 large US metropolitan areas concluded that higher rates of drug arrests did not correspond to lower rates of drug injecting.⁵⁸

Rather than decreasing drug use, empirical evidence shows that drug law enforcement can have exactly the opposite effect. In the US, where one-eighth of young adults report that their biological father has been incarcerated at some time, a recent study found that paternal incarceration was significantly associated with adolescent drug use, even after taking into account other factors such as family background and individual characteristics.⁵⁹ These types of unintended consequences of the war on drugs on families may help to explain why, for example, rates of cannabis use remain consistently higher in the US than in Portugal, where cannabis use has been decriminalized, or in the Netherlands, where cannabis sales have been quasi-legalized.^{44,60}

The evidence clearly suggests that health-based policies do not increase rates of drug use but rather have the potential to significantly decrease rates of use. Numerous reviews have proven, for example, that drug use is not increased by syringe exchange programs.⁶¹ Similarly, supervised injecting facilities, where drug users can inject street-obtained illicit drugs

under the supervision of medical staff, have proven to increase the use of addiction treatment and to reduce rates of drug injecting.⁶² Likewise, the initiation of a harm reduction approach to heroin use in Switzerland that included heroin prescription programs coincided with a sustained decrease in the number of new heroin users. Specifically, between 1990 and 2002, the annual number of new heroin users dropped by 82 percent, from 850 to 150, and the overall population of heroin users declined by 4 percent per year during that time.⁶³ A recent review of heroin prescription trials recently concluded: “The available evidence suggests an added value of heroin prescribed alongside flexible doses of methadone for long-term, treatment refractory, opioid users, to reach a decrease in the use of illicit substances, involvement in criminal activity and incarceration, a possible reduction in mortality; and an increase in retention in treatment.”⁶⁴ Decreased injection drug use despite expanded access to sterile syringes has now been reported from several different areas.^{32,43} Indeed, rather than increasing drug use, there is strong evidence to suggest that a public health approach to drug addiction can reduce rates of use.

A Time for Leadership

With the HIV epidemic continuing to grow among persons who use drugs, the time for national and international leadership is now. Within the United Nations system, key organizations, including the Joint United Nations Programme on HIV/AIDS and the World Health Organization, have for too long remained on the sidelines while the war on drugs has fueled the HIV epidemic. While the Office for the High Commissioner for Human Rights has pushed for more balanced and comprehensive policies, other UN organizations, such as the United Nations Office on Drugs and Crime and especially the International Narcotics Control Board (INCB), persist in pursuing an aggressive drug law enforcement agenda at the expense of public health approaches.⁶⁵ While the INCB’s mandate includes ensuring that countries address medical needs for controlled substances, such as the use of methadone in treating opioid dependence, the board has a long history of decrying the spread of HIV linked to drug injection but doing little or nothing to push Russia and other countries that restrict medical access to methadone. A UN-supported institution that should play a key role in access to opioid replacement therapies rather chooses to praise repressive law enforcement in

the name of treaty compliance. Most recently, the INCB refused to join many other UN entities in condemning compulsory drug “treatment” centers and has consistently refused to condemn the application of the death penalty to drug-related crimes.

Unfortunately, any sober assessment of the impacts of the war on drugs demonstrates that many national and international organizations tasked with reducing the drug problem have actually contributed to a worsening of community health and safety. This status quo must change.

Fortunately, the longstanding silence regarding the harms of the war on drugs is being broken as a result of courageous leadership coming from many circles. The Vienna Declaration, as well as a range of other statements from leaders in science, medicine and public health, have highlighted the need for drug policies to be based on empirical evidence and not on drug war ideology.^{3,66}

In Latin America, Colombian President Juan Manuel Santos, Guatemalan President Otto Fernando Pérez Molina and Costa Rican President Laura Chinchilla have signaled their support for a rethinking of the war-on-drugs approach.

Interestingly, in the United States, cracks in support for the war on drugs are also beginning to show, especially among those viewed to be traditional supporters. This change is appearing across the political spectrum, with conservative groups such as the Right on Crime initiative, as well as two US Republican presidential nomination candidates, recently leading the discussion about how to meaningfully reduce incarceration and end the war on drugs.⁶⁷ In addition, in 2012, a number of US states will consider ballot initiatives to tax and regulate cannabis.

We fully endorse these bold and pragmatic initiatives, which are entirely consistent with the Global Commission’s view of placing community health and safety as a priority in designing drug policies, and also with the Commission’s support for de-criminalization of drug use and experimentation with models of legal regulation.

The Vienna Declaration: Scientific Support for the Global Commission's Call for Change

The Vienna Declaration is a scientific statement seeking to improve community health and safety by calling for evidence-based policies on illegal drugs. It was drafted by a writing committee of international experts in the fields of HIV/AIDS, drug policy and public health, under the leadership of the International AIDS Society.

The Vienna Declaration was adopted as the official conference declaration of the XVIII International AIDS Conference, held in Vienna from July 18 to 23, 2010. This was one of the world's largest public health conferences, attracting more than 20,000 delegates. It was convened by the International AIDS Society along with various international conference partners, including the World Health Organization, the Joint United Nations Programme on HIV/AIDS (UNAIDS), the United Nations Office on Drugs and Crime (UNODC) and the European Commission.

The Declaration stressed that the war on drugs had not achieved its stated objectives and called for its harmful consequences to be acknowledged

and addressed. Following the Declaration's launch, more than 20,000 individuals and more than 400 high-level organizations from every region of the globe endorsed the statement. Among the signatories to date are several Nobel laureates, thousands of scientific and academic experts, a diversity of health, faith-based, and civil society organizations, law enforcement leaders, and the judiciary from countries around the world. Signatories to the Vienna Declaration specifically call upon governments and international organizations, including the United Nations, to:

- Undertake a transparent review of the effectiveness of current drug policies;
- Implement and evaluate a science-based public health approach to address the individual and community harms stemming from illicit drug use;
- Decriminalize drug users, scale up evidence-based drug dependence treatment options and abolish ineffective compulsory drug treatment centers that violate the Universal Declaration of Human Rights;
- Unequivocally endorse and scale up funding for the implementation of the comprehensive package of HIV interventions spelled out in the WHO, UNODC and UNAIDS Target Setting Guide;
- Meaningfully involve members of the affected community in developing, monitoring and implementing services and policies that affect their lives.

Anand Grover, the UN Special Rapporteur on the right to the highest attainable standard of health, wrote of the Vienna Declaration:

"The right to health is an inclusive right, extending not only to timely and appropriate health care, but also to the underlying determinants of health, such as widespread implementation of harm-reduction initiatives. The criminalization of drug users does not benefit society and it worsens public health and contributes to serious human rights violations. Decriminalizing drug users, as outlined by the Vienna Declaration, would improve the health and welfare of people who use drugs and communities in general and must be recognized by governments, policy-makers, and individuals worldwide."

**Support Drug Policy
Based On Science,
Not Ideology.**

**THE VIENNA
DECLARATION**

**Sign on at
www.viennadeclaration.com**

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RECOMMENDATIONS OF THE GLOBAL COMMISSION ON DRUG POLICY'S 2011 "WAR ON DRUGS" REPORT

1. Break the taboo. Pursue an open debate and promote policies that effectively reduce consumption, and that prevent and reduce harms related to drug use and drug control policies. Increase investment in research and analysis into the impact of different policies and programs.
2. Replace the criminalization and punishment of people who use drugs with the offer of health and treatment services to those who need them.
3. Encourage experimentation by governments with models of legal regulation of drugs (with cannabis, for example) that are designed to undermine the power of organized crime and safeguard the health and security of their citizens.
4. Establish better metrics, indicators and goals to measure progress.
5. Challenge, rather than reinforce, common misconceptions about drug markets, drug use and drug dependence.
6. Countries that continue to invest mostly in a law enforcement approach (despite the evidence) should focus their repressive actions on violent organized crime and drug traffickers, in order to reduce the harms associated with the illicit drug market.
7. Promote alternative sentences for small-scale and first-time drug dealers.
8. Invest more resources in evidence-based prevention, with a special focus on youth.
9. Offer a wide and easily accessible range of options for treatment and care for drug dependence, including substitution and heroin-assisted treatment, with special attention to those most at risk, including those in prisons and other custodial settings.
10. The United Nations system must provide leadership in the reform of global drug policy. This means promoting an effective approach based on evidence, supporting countries to develop drug policies that suit their context and meet their needs, and ensuring coherence among various UN agencies, policies and conventions.
11. Act urgently: The war on drugs has failed, and policies need to change now.

GLOBAL COMMISSION ON DRUG POLICY

The purpose of the Global Commission on Drug Policy is to bring to the international level an informed, science-based discussion about humane and effective ways to reduce the harm caused by drugs to people and societies.

GOALS

- Review the basic assumptions, effectiveness and consequences of the 'war on drugs' approach
- Evaluate the risks and benefits of different national responses to the drug problem
- Develop actionable, evidence-based recommendations for constructive legal and policy reform

