KYRGYZSTAN

SUMMARY REPORT AND RECOMMENDATIONS
KYRGYZSTAN: SUMMARY REPORT AND RECOMMENDATIONS

1. BACKGROUND

Early introduction of HIV prevention measures for people who use drugs and prisoners in the Kyrgyz Republic, such as opioid substitution therapy and needle and syringe programmes (including in prisons), demonstrate the country’s advanced approach to addressing HIV/AIDS. Nonetheless, there are features of the republic’s legislation and policy that persist as barriers impeding effective HIV prevention among these particularly vulnerable groups. According to the analysis prepared by the national expert group, various human rights are not yet fully observed and discrimination against persons living with HIV and various vulnerable groups is widespread. Both positive and problematic aspects of Kyrgyz law and policy are discussed and analysed in detail below, and numerous recommendations for strengthening the country’s response to HIV among these populations are presented.

The Ministry of Health reported the total cumulative number of HIV cases as of the end of 2008 was 1479; in 2008, there were 409 new HIV infections recorded. HIV prevalence is less than 1 percent (estimated at roughly 26 cases per 100,000 people). As of 1 August 2007, 66 people in Kyrgyzstan (including 6 women), were receiving antiretroviral (ARV) therapy.

In 2002, the UN Office on Drugs and Crime estimated that 2.3% of the adult population (those between the ages of 15 and 64) were problem users of opioids, and 80% of them used heroin. According to data from the National Narcology Centre of the Ministry of Health, as supplied by UNODC, by 2006 the total cumulative number of people registered as drug users was 7842; the estimated prevalence of injection drug use in the country at that time was 0.76%, with the greatest concentration found in Bishkek, the capital, and in the Osh and Chui provinces. According to the same source, 68% of the total number of people registered as drug users were injecting drugs (5387 people). In 2005, it had been estimated that about 6.7 percent of those in the country with a dependence on narcotic drugs or psychoactive substances are women.

According to the information provided by UNODC, up to 72% of all newly diagnosed HIV infections happen among people who inject drugs. In 2007, the number of HIV cases among people who use drugs was 7.4%. But the coverage of drug users by prevention services is low – at the end of 2007, harm reduction programmes covered approximately 50.4% of the total estimated number of people who need them. Methadone substitution treatment by the end of 2007 was provided to 444 people.

HIV and drug use are concerns in prisons in Kyrgyzstan as well. As of January 2008, 401 people in prison were registered as drug-dependent. UNODC cites the results of several studies, indicating that approximately 35% of the total number of prisoners use drugs, with 50% of this number injecting drugs. As of 1 January 2007, there were 739 people registered in health care facilities and undergoing court-ordered compulsory treatment for drug dependence.

In 2006, the penitentiary system registered 21 cases of viral hepatitis, 237 cases of syphilis, 21 cases of gonorrhoea and 41 new HIV infections. As of 31 December 2007, there were 137 prisoners in the country known to be HIV-positive, 6 of them receiving ARV therapy. In 2008, the Ministry of Health reported the total number of 178 of prisoners with HIV, including 12 prisoners with HIV/tuberculosis co-infection.

816 For some earlier discussion of ways in which Kyrgyzstan has demonstrated regional leadership in responding to injection drug use and related health concerns, see D. Wolfe, Pointing the Way: Harm Reduction in Kyrgyz Republic (Harm Reduction Association of Kyrgyzstan, 2005), online: http://www.soros.org/initiatives/health/focus/ihrd/articles_publications/publications/pointing_20050523 (in English and Russian).
817 Data provided by the national expert group and the Central Asian Regional UNODC office [on file].
819 Statistical information provided by the national expert group [on file].
820 Ibid.
822 Data provided by the national expert group [on file].
2. NATIONAL PROGRAMMES AND STRATEGIES

Programme on HIV/AIDS
In Kyrgyzstan, the main objectives of the “Government Programme for the prevention of the HIV/AIDS epidemic and its social and economic consequences in the Kyrgyz Republic for 2006-2010” are preventing HIV through initiatives focussed on vulnerable groups of population and providing assistance to those living with HIV/AIDS.\textsuperscript{823} Harm reduction is an explicit goal of this Programme, and there are explicit initiatives identified in relation to people who use drugs and for prisoners. In addition, the national AIDS Programme makes explicit reference to the need to advance the rights of people living with or vulnerable to HIV.

Strategy 2.2 of the Programme (“Reduced vulnerability to HIV/AIDS of injecting drug users and other co-dependent persons [взрослые лица]”) envisages increased coverage of harm reduction programmes for injecting drug users, through the following activities:

- undertaking a situation analysis and assessing the needs of injecting drug users and drug-dependent persons in relation to HIV/AIDS;
- creating new, and developing existing, programmes of syringe exchange in all regions of the country, by both governmental and non-governmental organizations, as well as strengthening the capacity of people who use drugs to run these programmes;
- creating incentives for civil society, grassroots organizations, and organisations of people who use drugs and to organize partnerships to reach more than 60\% of the target group with services;
- introducing substitution therapy programmes;
- assisting in the development and expansion of the network of harm reduction programmes with the participation of the state, international and non-governmental organizations.

The national AIDS programme also calls for expanding harm reduction programmes in penitentiary facilities. Strategy 2.3 (“Reduced vulnerability to HIV/AIDS among prisoners and the personnel of the penitentiary establishments”) deals directly with the expansion of programmes of harm reduction in penitentiary establishments and includes the following activities:

- improving the infrastructure and activities of syringes exchange programmes in penitentiaries;
- introducing substitution therapy programme for prisoners who are dependent on drugs;
- training of staff in the penitentiary facilities in providing harm reduction services;
- delivering regular motivational trainings for prisoners on safe behaviours and abstaining from drug use in all penitentiary institutions;
- expanding existing, and introducing new, effective programmes of rehabilitation for people who use drugs; and
- implementing measures to develop safer sex skills and supplying condoms.

According to the Kyrgyz national expert group, currently the participation of people living with HIV (PLHIV) or people affected by the epidemic in HIV prevention programmes remains insignificant. The national expert group has also reported that often the rights of persons belonging to vulnerable groups are infringed. However, the national AIDS Programme includes the empowerment of people living with HIV as a key strategy (Strategy 2.7), and includes the objectives of: developing the community of PLHIV and people affected by HIV/AIDS to improve quality of life; promoting tolerant attitudes toward PLHIV; establishing interaction with heads of governmental and non-governmental organizations to overcome stigma and discrimination; and increasing the participation of PLHIV in all stages of developing, implementing and monitoring of State programmes on HIV/AIDS.\textsuperscript{824} To this end, the following activities are planned:


\textsuperscript{824} One of the declared main principles of state policy in the area of health protection is the active participation of the population and public organizations in addressing problems of health protection: Law “On health protection in the Kyrgyz Republic” [Об охране здоровья граждан в Кыргызской Республике], Law No. 6 (9 January 2005), Article 4 [hereinafter Law “On health protection”].
- providing support to groups of PLHIV by training and increasing leadership potential of groups and individual representatives of the PLHIV community;
- mobilizing financial resources of the PLHIV community; and
- building its capacity to protect rights and interests of its members.

Finally, it is worth noting Strategy 3.3 of the national AIDS programme (“Programmes of legal support to persons living with HIV/AIDS and representatives of vulnerable groups of the population”), which has the declared objective of enhanced legal security of PLHIV and representatives of vulnerable groups. Activities in this area are to include:

- providing free and accessible legal aid services for PLHIV and representatives of vulnerable groups;
- monitoring and assessing the human rights needs of PLHIV and representatives of vulnerable groups; and
- promoting tolerant attitudes toward PLHIV and representatives of vulnerable groups through educational institutes, media, cultural and religious institutions, legal system and state policy.

As stated by the Law “On HIV/AIDS in the Kyrgyz Republic”, financing for targeted HIV/AIDS programmes comes from: (a) the national and local budgets of the Kyrgyz Republic; (b) loans, grants and trust funds; (c) medical insurance; and (d) other sources. According to the national expert group, insufficient funds have been allocated for implementing the national AIDS programme. For example, the Law “On the national budget of the Kyrgyz Republic for 2007” did not contain funding for HIV prevention. Besides, the social and economic situation in Kyrgyzstan allows little room for funding HIV prevention efforts from the state budget; the majority of funding for HIV prevention comes from external sources. According to the national expert group, an effective implementation of the national AIDS programme requires more funding from the national budget and its careful allocation. In addition, there is a need to define more clearly the responsibility of various governmental bodies for implementing the programme and ensuring its effectiveness.

The government has introduced other measures to address other diseases of relevance to PLHIV and vulnerable populations such as people who use drugs and prisoners. For example, PLHIV and many people who use drugs and prisoners are particularly vulnerable to tuberculosis. The National Programme on Tuberculosis-III for 2006–2010 provides for various initiatives aimed at prevention, early detection and treatment of tuberculosis among prisoners in correctional facilities, including ensuring 100 percent coverage among prisoners with tuberculosis by directly-observed therapy (short-course) (DOTS). In addition, the programme calls for measures to improve sanitary, housing and food conditions in prisons for prisoners with tuberculosis. The Ministry of Health has also issued an important order on viral hepatitis prevention, yet it contains no provisions for hepatitis prevention among injection drug users, even though they are the primary group infected and at risk.

Programme on drugs
At this writing, Kyrgyzstan is implementing the “Concept against drug dependence and drug trafficking” and the “National Programme of the Kyrgyz Republic against drug dependence and drug trafficking for the period until 2010.” The Concept and the National Programme contain elements of prevention of drug (mis)use, treatment of drug dependence, law enforcement measures and certain elements of harm reduction. Under the Concept, the Drug Control Agency of the Kyrgyz Republic has responsibility for coordinating and supervising efforts to counteract both narcotic addiction and drug trafficking. The Concept also mentions that non-governmental organizations must have an opportunity to monitor implementation of the programme, thus providing at least some opportunity for possible oversight of law enforcement by civil society.

828 Ministry of Health, Order “On measures to reduce prevalence of viral hepatitis” [О мерах по снижению заболеваемости вирусными гепатитами в республике], Order No. 222 (15 June 1999).
829 Concept of counteraction of drug dependence and drug trafficking [Концепция противодействия распространению наркомании и незаконному обороту наркотиков] and the National Program of the Kyrgyz Republic to counteract drug dependence and drug trafficking for the period until 2010 [Национальная программа Кыргызской Республики по противодействию наркомании и незаконному обороту наркотиков на период до 2010 года], both approved by the Decree of the President of the Kyrgyz Republic, Decree No. 445 (22 December 2004).
3. ADMINISTRATIVE AND CRIMINAL LAW PROVISIONS ON DRUGS

The Law “On narcotic drugs, psychotropic substances and precursors” defines “illicit drug use” as “drug use without medical prescription.” Narcotic drugs, psychotropic substances and precursors may be used for medical and scientific purposes. The Law prohibits any form of advertising of narcotic drugs, psychotropic substances and precursors, and growing plans containing narcotic substances. However, as in other legal systems of the region, the law does not define liability, which is established in administrative and criminal codes. The Law also has detailed provisions on drug testing and compulsory drug dependence treatment, which are highlighted below (in Section 4).

The Government of Kyrgyzstan adopts a list of narcotic drugs and psychotropic substances that are prohibited or controlled in Kyrgyzstan, based on recommendations of the Drug Control Agency. The document also establishes the quantity of narcotic drugs and psychotropic substances sufficient for classifying offences as either administrative offences or criminal offences. The Government approved the current quantities of narcotic drugs and psychotropic substances in November 2007. According to the information and analysis provided by the national expert group of Kyrgyzstan, this document defines amounts of illegal drugs as including whatever fillers (e.g., flour) they might contain, as opposed to pure amounts of illegal drugs. According to the national expert group, this provision should be reformed so that any administrative or criminal liability is based solely on pure amounts of illicit drugs.

**Administrative offences**

The Code of the Republic of Kyrgyzstan on Administrative Responsibility defines the following as administrative offences:

- The “use of narcotics or psychotropic substances, the consumption of alcohol in the streets, stadiums, parks, in public transport and in other public places, or appearing in public in a state of intoxication that offends human dignity and social morality” is punishable by a fine. A repeat offence within one year of a first offence is punishable with a heavier fine. While the drafting is ambiguous, it appears that this article creates three distinct administrative offences: a) the mere use of narcotics or psychotropic substances; b) drinking alcohol in public; and c) appearance in public in the condition of intoxication that offends human dignity and social morality.

- Illegal possession, transportation or transfer of narcotics or psychotropic substances without an intention to sell and in a “small quantity” [небольшие размеры] is punishable by a fine or administrative arrest for up to five days. A repeat offence within a year is punishable by administrative arrest for a term of five to fifteen days.

- Infringement of the prescribed rules governing the manufacture and legal circulation of narcotics is punishable by a fine.

- Cultivating prohibited narcotics in a “small quantity” [небольшие размеры], and failure to take measures to destroy wild-growing narcotic plants by persons responsible for land plots, are both punishable by a fine.
Being intoxicated by alcohol or a narcotic or psychotropic substance while committing an administrative offence is an aggravating circumstance that can result in a harsher penalty.\textsuperscript{840}

The national expert group’s analysis flags an additional concern. The Administrative Code (Article 366) prohibits “use of narcotics or psychotropic substances, drinking of alcohol or appearance in the public in the condition of intoxication offending human dignity”. In light of identified concerns about corruption in the law-enforcement system, the concern is that such a provision creates additional opportunities for unscrupulous police to target people for detention and threatened charges merely for using drugs or for being under the influence of alcohol or drugs in a public place. The national expert group has also identified the concern that such widespread penalization of drug users undermines the effective realization of harm reduction programmes and HIV prevention in the country, creating additional barriers to these services by penalizing people merely for using drugs, a behaviour that needs to be addressed via health services rather than through criminal prosecution and penalties.

\textbf{Criminal offences}

In relation to prohibited drugs, the Kyrgyz Criminal Code\textsuperscript{841} distinguishes between activities committed “with intention to sell” and “without intention to sell”. (The law does not contain the concept of possessing drugs “for personal use”). The following are criminal offences under current Kyrgyz law: \textsuperscript{842}

- Illegally manufacturing, acquiring, possessing, transporting or mailing narcotic drugs or psychotropic substances in a “small quantity” [небольшие размеры], when committed \textit{without an intention to sell and after} an administrative fine has been imposed for the same offence, is punishable by “communal works”, \textsuperscript{843} \textit{a fine, the restriction of freedom for up to two years or imprisonment for up to two years}. \textsuperscript{844}

- Illegally manufacturing [изготовление], acquiring, possessing, transporting or mailing \textit{any quantity} of narcotic drugs or psychotropic substances \textit{with an intention to sell}, or the illegal production [производство] or sale of \textit{any quantity} of narcotic drugs, psychotropic substances, or their analogues or precursors, is punishable by imprisonment for a term of four to eight years. An offence that involves a “large quantity” [крупные размеры] attracts a more serious penalty, such as eight to twenty years’ imprisonment, and the confiscation of property. \textsuperscript{845}

- “Inducement” to consume narcotic drugs or psychotropic substances is punishable by “corrective works”\textsuperscript{846} for up to two years, restriction of freedom for up to three years or imprisonment for up to two years. If committed in conspiracy by a group of persons, this same offence is punishable by corrective works for up to three years, restriction of freedom for up to five years or imprisonment for up to five years. \textsuperscript{847}

- The cultivation of narcotic plants in a “small quantity” [небольшие размеры], committed again within a year after receiving an administrative penalty, is punishable by a fine, corrective works for up to three years or imprisonment from two to five years, with or without the additional confiscation of property. \textsuperscript{848}

\begin{flushright}
\textsuperscript{840} Administrative Code, Article 43.
\textsuperscript{841} Criminal Code of the Kyrgyz Republic, Law No. 68 (1 October 1997) [hereinafter “Criminal Code”].
\textsuperscript{842} The minimum age for general criminal liability is 16 years old. However, for certain “grave” crimes — which includes not only such crimes as murder but also the illegal manufacturing, purchase, possession, transportation or mailing of narcotic drugs with the purpose of sale, or the actual sale, of drugs (Article 247), and stealing or extortion of narcotic drugs (Article 248) — the minimum age for criminal liability is 14: Criminal Code, Article 18.
\textsuperscript{843} “Communal work” [общественные работы] (i.e., community service) is an alternative to incarceration, and is performed while the sentenced person continues his or her studies, employment, etc., during free time, without remuneration. The duration of communal work is from 40 to 100 hours. See: Criminal Code, Article 43.
\textsuperscript{844} Criminal Code, Article 246.
\textsuperscript{845} Criminal Code, Article 247.
\textsuperscript{846} “Corrective work” [исправительные работы] is a more serious punishment than “communal work”, also used as an alternative to incarceration when the person constitutes no danger to society, for “insignificant” and “less serious” offences [преступления небольшой тяжести и менее тяжкие преступления]. Corrective work is performed in the region of person’s residence, and could be performed at one’s regular place of employment. A portion (usually 5–20%) of the person’s wage during the period of corrective work is directed to the state budget. The duration of corrective work is from 3 month to 3 years. See: Criminal Code, Article 46-2.
\textsuperscript{847} Criminal Code, Article 249.
\textsuperscript{848} Criminal Code, Article 250.
\end{flushright}
Organizing or maintaining a site for the consumption of narcotic drugs, or allowing premises to be used for this purpose, is punishable by corrective works for up to two years, restriction of freedom for up to three years or imprisonment for up to three years, with or without the additional confiscation of property. If committed in conspiracy by a group of persons this same offence is punishable by restriction of freedom for three to five years or imprisonment for up to five years.

Being intoxicated by alcohol or a narcotic or psychotropic substance while committing a criminal offence is an aggravating circumstance that can result in a harsher penalty.

According to the Criminal Code (Article 42), non-custodial sentences include the following options: 1) communal works; 2) fine; 3) threefold ayip (compensation of damages); 4) deprivation of the right to occupy certain posts or be engaged in certain activities; 5) public apology with compensation of damages; 6) corrective works; and 7) restriction of freedom. Fines, a public apology accompanied by compensation of damages, and the deprivation of the right to occupy certain posts or to be engaged in certain activities, all may be applied in addition to any other kind of penalty. Instead of sentencing a person to imprisonment, the court may give an offender a conditional sentence, taking into account the personality of an offender and the danger posed by the offence.

In 2007, Kyrgyzstan implemented reforms aimed at “humanizing” its drug laws. Specifically, it took steps to “partially decriminalize” certain activities involving drugs without an intention to sell. However, as noted by the national expert group, the full decriminalization of drug use and of possession without intention to sell has not yet been achieved. As a result of the 2007 amendments, the Criminal Code still prohibits manufacturing, acquiring, possessing, transporting or mailing narcotic drugs or psychotropic substances in a “small quantity” [небольшие размеры], even without an intention to sell, if committed within a year after receiving an administrative fine for the same offence and by a person who earlier committed any offence connected with drugs. In other words, a first offence is but administrative in nature; a repeat offence is a crime — any decriminalization is of a very limited nature, and given the nature of drug dependence as a chronic, relapsing condition into drug use (and hence possession), Kyrgyz law still effectively criminalizes many people with drug dependence. Furthermore, concern remains with the very restrictive approach to defining a “small quantity” of drugs; this, too, requires attention in order effectively to decriminalize people who use drugs (including those with drug dependence). The national expert group concluded that the defined quantities of narcotic substances and psychotropic substances currently in effect in Kyrgyzstan do not meet modern realities and recommended revising these definitions with a view to decriminalizing the acquisition and possession of narcotic drugs and psychotropic substances without an intention to sell in quantities that reflect realistically the use of such drugs by individuals, particularly by people with dependence.

Needle and syringe programmes: legal issues

Neither the Administrative Code nor the Criminal Code penalize the possession of accessories for drug use, including syringes and needles. The National Drug Control Commission under the auspices of the Government of Kyrgyzstan is responsible for the control of tools and equipment that can be used for the illegal manufacturing of narcotics, but fortunately, needles and syringes are not included among the definition of “tools and equipment.”

However, the national expert group has also observed that there are no legislative provisions that explicitly exclude harm reduction programmes from the sphere of criminal and administrative law, and has

849 Criminal Code, Article 252.
850 Criminal Code, Article 55(16).
851 Criminal Code, Article 45: “Threefold ayip is a compensation imposed by a court as triple the amount of the inflicted damage in monetary or natural form. Two parts of the threefold ayip are payable to the victim to compensate for material and mental harm, and the third part is collected by the state. This punishment is applied to persons convicted of a deliberate crime for the first time.”
852 Criminal Code, Article 63.
854 “The list of tools and equipment under special control and used in illegal manufacturing of narcotic, psychotropic or strong substances” [Список инструментов и оборудования, находящихся под специальным контролем и используемых при незаконном изготовлении наркотических средств, психотропных или сильнодействующих веществ] approved by State Drug Control Commission under the auspices of the Government of Kyrgyzstan, Order No. 3 (4 May 2000).
noted two issues in particular that warrant further attention.

First, criminal and administrative liability is possible based on a residual quantity of drugs in a syringe or on other drug use equipment, with fillers included in the determining the quantity. As noted by the national expert group, the Government Order defining different quantities of drugs for administrative and criminal law purposes establishes only the upper limit of the “small quantity" (небольшие размеры) of various narcotic drugs and psychotropic substances, and does not define the lower limit of this category to reflect minimal amounts. In other words, the legal category of “small” quantity includes any quantity, however minimal. For example, the residual quantity of drug in a syringe could potentially be a basis for a prosecution. The expert group has noted that this potentially undermines the use of harm reduction programmes such as needle and syringe programmes, including the safe return and disposal of used injection equipment that carries residual amounts of prohibited drugs, since being found in possession of such an item can then become the basis for a charge.

Second, the national expert group noted a concern about the Criminal Code provision on “incitement" to drug use. Theoretically, outreach workers, peer consultants, and staff of harm reduction programmes such as needle exchanges could run afoul of this provision if they are treated as “inciting” someone to drug use by providing sterile drug-use equipment or education about how to use drugs in ways that minimize the risk of HIV infection or other harms.

On an encouraging note, however, it is also worth noting that the Ministry of Internal Affairs has issued official instructions to law enforcement personnel stating that:

> With a view toward HIV prevention, employees of the regional office of the Ministry of Internal Affairs (OVD) shall cooperate with governmental and non-governmental organizations running harm reduction programmes (e.g., needle and syringe exchange, methadone programmes), and shall inform people who use drugs and their relatives about harm reduction programmes, telephone hotlines, self-help groups and anonymous groups of people with drug dependence.855

**Compulsory drug testing by law enforcement authorities**

The law provides several bases on which police, investigative authorities and courts may subject a person to drug testing without his or her consent. According to the information reported by the national expert group, involuntary testing may be conducted:

- based on the grounds provided by the Administrative Code (i.e., consumption of alcohol or drugs in public place, driving vehicles in a condition of intoxication);
- in the case of a car/transportation accident (testing of those involved in the accident);
- in connection with the commission of a criminal offence, or even simple suspicion of having committed such an offence.

Drug testing is performed upon request by the police; a full medical examination (to determine drug dependence) is done under the supervision of a narcologist of official public health care bodies of Kyrgyzstan.856 Refusal to undergo testing or medical examination leads to compulsory referral to a narcological facility by police, and compulsory testing/examination without consent.

**High risk groups: criminal and administrative law issues**

**Human rights abuses against sex workers**

Sex work _per se_ is not prohibited in Kyrgyzstan, which is a positive feature. The Criminal Code does pro-


856 The procedure for referral for drug testing is regulated by the Law “On narcotic drugs, psychotropic substances and precursors” [О наркотических средствах, психотропных веществах и прекурсорах], Law No. 66 (22 May 1998), and by Government Regulation “On the procedure of physical examination to determine intoxication or the fact of using psychoactive substances in the Kyrgyz Republic” [Положение о порядке проведения медицинского освидетельствования на предмет установления состояния опьянения или факта употребления психоактивных веществ в Кыргызской Республике], Regulation No. 137 (2 May 2001); Regulation “On the conduct of the expert judicial narcological assessment in the Kyrgyz Republic” [Положение о производстве судебно-наркологической экспертизы в Кыргызской Республике], Regulation No. 137 (2 May 2001).
hibit “involving another in sex work using violence, threats and coercion” and “organising and maintaining brothels for prostitution” — the former provision is important to protect human rights, but the latter provision, depending on how it is interpreted and applied, could pose a problem for sex workers’ ability to control their own working conditions and better protect their own safety, including with respect to HIV and STI prevention. The national expert group has noted that police abuse and harassment of sex workers remain of concern. According to the group, it is common for police to arrest and charge sex workers for such things as “debauchery”, violation of public order, disobeying police officers or the absence of identification documents. The national expert group has also noted that there is evidence of forced testing for sexually transmitted infections (STIs), which could then lead to administrative charges for avoiding STI treatment. (The human rights concerns of coercive testing and treatment more generally are discussed further in Section 4 below.) Harassment of sex workers contributes to their further stigmatization and marginalization, putting them at greater risk of human rights abuses and exacerbating vulnerability to HIV. It is recommended to conduct educational trainings and seminars with law enforcement personnel, aimed at ceasing this practice.

STI and HIV exposure and transmission
The following are offences under the Criminal Code:

- Knowingly exposing someone to HIV infection is punishable by correctional works, limitation of freedom or imprisonment, all for up to one year. HIV transmission by a person who was aware of his or her infection is punishable by limitation of freedom for up to five years or imprisonment for up to five years, and transmission to two or more people or to a minor is punishable by imprisonment for up to five years. (Note that a person is not liable for either offence if he or she disclosed his or her HIV infection and the partner agreed to the risk behaviour.)
- Transmission of other “venereal disease” by someone who was aware of his or her infection is punishable with a fine, limitation of freedom for up to three years or imprisonment for up to three years. A second or subsequent offence, or transmission to two or more people or to a minor, is punishable by imprisonment for up to five years.
- HIV transmission as a result of negligent performance of professional duties by a health care professional is punishable by limitation of freedom for up to five years or imprisonment for up to five years with a prohibition to hold certain positions for up to three years.

Having a specific criminal offence singling out HIV exposure and negligent HIV and STI transmission runs contrary to internationally recommended policy, in part because it stigmatizes people living with HIV, and people vulnerable to it, and may create a further disincentive for HIV testing and an additional barrier to access to health services. The International Guidelines on HIV/AIDS and Human Rights recommend against such an approach: criminal legislation should not include specific offences regarding HIV transmission or exposure, and the scope of applying criminal law should be limited to those cases where someone acts with malicious intent to transmit HIV and does in fact transmit the virus.

857 Criminal Code, Article 260.
858 Criminal Code, Article 261.
859 Ibid., Article 117(1).
860 Ibid., Article 117(1).
861 Ibid., Article 117(2) and (3).
862 Ibid., Article 118.
4. HEATH SYSTEM AND SERVICES

The right to health is guaranteed in the Constitution of the Kyrgyz Republic: "citizens of the Kyrgyz Republic have the right to health protection."864 In addition, the Law "On health protection in the Kyrgyz Republic"865 defines the right of citizens to health protection and establishes that health care is provided through (a) granting everybody equal possibilities in realization of the right to receive medical, sanitary and social assistance; and (b) granting medical and sanitary assistance throughout the entire country.866

In Kyrgyzstan, there is no general free access to medical services for the population. Free of charge health care services and medications are provided only within the context of emergency medical care.867 In other cases, health care is provided under obligatory medical insurance.868 According to the Law "On medical insurance of citizens in the Kyrgyz Republic", persons who are not covered by the system of obligatory medical insurance pay for medical, preventive, rehabilitation and other health services on their own. If they are officially insured under the obligatory health care insurance, unemployed persons have the right to receive some free health care services.869

Rules and regulations attach citizens to public health services based on territorial location.870 The national expert group has noted that these rules were designed so as to give patients a free choice of family doctors, and to ensure availability and guarantees of qualitative primary medical assistance. Homeless people can count only on receiving emergency and urgent health care assistance free of charge.

Medication is provided according to the Programme of State Guarantees, based on the "List of Essential Medicines and Medical Products" approved by the Government of Kyrgyzstan, with funds allocated from the state budget and obligatory medical insurance.871 The scope and quantities of medicines and medical products provided by the state may be expanded with funding from municipalities, local budgets and international aid.

4A. DRUG DEPENDENCE PREVENTION AND TREATMENT

According to the analysis performed by the national expert group currently, Kyrgyzstan has an inadequate legal framework for the prevention and treatment of drug dependence. The Law "On narcotics, psychotropic substances and precursors" focuses almost exclusively on drug control, and does not address problems of prevention and treatment of drug dependence. Only Article 38 of the Law mentions voluntary treatment, in general terms.

Treatment of drug dependence may be carried out in both state and private health care facilities.872 Drug dependence treatment is also conducted in medical institutions of the penitentiary system, private narco logical clinics and in a number of non-governmental organizations. Treatment in a narcological hospital is conducted based on co-payment by the patient: the Programme of State Guarantees covers part of the

865 Law "On health protection in the Kyrgyz Republic", Law No. 6 (9 January 2005).
866 Ibid., Article 61.
867 According to the Program of State Guarantees, all patients who arrived in hospitals in emergency situations are to receive emergency medical care free of charge.
870 Ministry of Health, "Temporary rules for registration of the population to groups of family doctors in the Chui, Issyk-Kul, Jalal-Abad provinces and Bishkek", Order No. 312 (21 July 2003).
cost and patients must pay any difference.\textsuperscript{873} Methods of treatment include detoxification programmes, medical and psychological rehabilitation and opioid substitution treatment. Narcological facilities carrying out detoxification operate in “closed doors” settings, with restriction of access of visitors and prohibition of patients going out of the facility without health care personnel or relatives, with the goal of preventing access to alcohol, drugs or other psychoactive substances.\textsuperscript{874}

Since 2004, the National Centre of Narcology has been using psychotherapeutic and rehabilitation techniques such as motivational counselling and training, group psychotherapy, socio-psychological trainings and “personal growth” groups.\textsuperscript{875} There is a rehabilitational department with psychotherapeutic and psychological services, rehabilitational environment, employment therapy and work with family members of patients. Narcological assistance includes subsequent care and rehabilitation of drug-dependent persons after treatment.

\textbf{Registration of people who use drugs and drug dependent people}

The National Centre of Narcology ensures registration of people with narcological disorders, a diagnosis established by psychiatrists or narcologists.

Removing someone from the registry requires a decision of the medical advisory commission and is based on the following grounds: death of the patient; departure of the patient from the country for permanent residence elsewhere; or recovery of the patient. In the case of dependence, “recovery” is defined as proven remission for at least three years; in the case of psychotic disorders without signs of drug dependence, “recovery” is defined as the absence of a relapse to drug use for one year.\textsuperscript{876}

According to the national expert group, patient’s medical history cards state the date a person was removed from the registry and on what basis. This information is stored separately from currently registered persons and is used for statistical purposes only. After the end of the calendar year, the cards are archived in the medical facility. All these details are “medical secrets”, the confidentiality of which is protected by law.\textsuperscript{877} The disclosure of data about patients and their diagnoses to governmental and non-governmental organizations that do not have powers of judicial and investigatory bodies is prohibited.\textsuperscript{878} According to the information provided by the national expert group, health care workers must share confidential information about patients receiving drug dependence treatment only upon official request by the police, investigative bodies, the public prosecutor or a court. However, they are not obliged to report to law enforcement authorities those patients who seek drug dependence treatment or overdose treatment. On this specific point, Kyrgyz law is more progressive than the legislation of some other countries of the region. There is room for further improvement, since failing to protect fully the confidentiality of patients receiving treatment for drug dependence can still create a disincentive for people to seek health services if this may result in investigation and possible prosecution by law enforcement authorities.

\textbf{Opioid substitution therapy}

Kyrgyzstan approved the use of opioid substitution therapy (OST) in 2001, becoming one of the first countries in the Commonwealth of Independent States to do so.\textsuperscript{879} In 2002, pilot programmes providing methadone maintenance therapy for patients with opioid dependence began at the National Centre of Narcology (in Bishkek) and the Osh regional narcological facility were introduced. In Bishkek, the programme was financed by the “Soros-Kyrgyzstan” Foundation and the Open Society Institute; in Osh it was funded by the United Nations Development Programme.\textsuperscript{880}

\textsuperscript{873} The order for co-funding is defined by the Statute on Co-Funding for the medical services provided by the organizations of public health services working in system of the 'Uniform Payer', (24 August 2007) NP 363.

\textsuperscript{874} Ministry of Health, “Instruction on the order and conditions of medical assistance in the narcological area” [О мерах по дальнейшему развитию и совершенствованию наркологической помощи в Кыргызской Республике], Order No. 65 (12 February 2004).

\textsuperscript{875} Ministry of Health, Order “On establishing departments of medical and psychological rehabilitation on the basis of the National Centre of Narcology,” Order No. 16 (16 January 2006) (within the scope of UNODC Project F75).

\textsuperscript{876} Regulation “On rules and procedure for registration and account of narcological disorder in the official bodies of public health services of the Kyrgyz Republic” [Положение о правилах и порядке регистрации и учета наркологических расстроств в государственных учреждениях здравоохранения Кыргызской Республики], (21 January 2002) No. 16.

\textsuperscript{877} Ibid.

\textsuperscript{878} Ibid., and also Law “On health protection in the Kyrgyz Republic” [Об охране здоровья граждан], Law No 6 (9 January 2005).

\textsuperscript{879} Order “On conditions and order of carrying out substitution therapy with methadone for people with drug dependence in the Kyrgyz Republic” [Об условиях и порядке проведения заместительной терапии лицам с наркотической зависимостью в Кыргызской Республике], Order No. 41 (15 February 2001).

\textsuperscript{880} For more, see Wolfe, Pointing the Way: Harm Reduction in Kyrgyz Republic.
Originally, the programmes started on a pilot basis and only in specialized narcological facilities. However, they have since been extended and OST is now implemented in subsidiaries of the original facilities, which are specialized hospitals providing in- and out-patient care (e.g., two additional programmes in the family medicine centres in Bishkek have been opened, funded by the Global Fund to Fight AIDS, Tuberculosis and Malaria).\(^\text{881}\) By the end of 2007, eight facilities were providing OST. Although first authorized in 2005, OST programmes were introduced in the penitentiary system in 2008.\(^\text{882}\)

OST using methadone is provided in specialized narcological facilities as long-term maintenance treatment; in some cases, it may also be used for short-term detoxification. Methadone is included in the list of essential medicines in the Kyrgyz Republic.\(^\text{883}\) According to regulations, OST is prescribed for the following purposes:

- improving the somatic and mental condition of patients with opium/opioid dependence and the timely detection and treatment of accompanying diseases;
- preventing HIV and hepatitis B and C infection among people who use drugs, and preventing and treating complications caused by intravenous drug use;
- improving the social adaptation and social reintegration of people with drug dependence;
- providing pre- and post-natal health care services to pregnant women who use drugs;
- assisting people with drug dependence and HIV in stopping injection drug use.\(^\text{884}\)

Selecting patients for OST programmes is the responsibility of a special advisory committee created within a medical institution by order of its chief physician. The committee considers such factors as:

- drug dependence on opioids;
- age (a minimum age of 18 is required);
- repeated in-patient drug dependence treatment in narcological facilities (at least twice);
- legal capacity (the ability to understand and be responsible for one’s actions);
- HIV infection;
- pregnancy; and
- belonging to a risk group (e.g., sex workers).\(^\text{885}\)

The advisory committee should also consider the following requirements: the patient’s dependence is exclusively on opioids (and patients with poly-drug dependence are not eligible); the patient’s expression of a voluntary desire to participate in the programme; the patient’s consent of the patient to stay in a particular city/town for not less than one year; and the patient’s consent to the non-anonymous, albeit confidential, nature of his or her participation in the programme.

A patient may be expelled from the programme on the following grounds:

- continued use of illicit drugs, despite warnings of the programme staff (determined by drug testing of blood or urine).\(^\text{886}\)

---

\(^\text{881}\) Ministry of Health and Drug Control Agency, Order “On further development of programs of substitution therapy for opioid addiction in the Kyrgyz Republic” [О дальнейшем развитии программ заместительной терапии при опиоидной зависимости в Кыргызской Республике], Joint Order No. 227/60 (3 May 2006 and 13 May 2006); and Ministry of Health and Drug Control Agency, Order “On expansion of the program of substitution supporting therapy with methadone for opioid dependence on the territory of Bishkek and Chuy region” [О расширении программы заместительной поддерживающей терапии метадоном при опиоидной зависимости на территории Бишкека и Чуйской области], Joint Order No. 56/15 (8 February 2007 and 14 February 2007).


\(^\text{884}\) Ministry of Health, Order “On conditions and procedures of substitution therapy with methadone in the Kyrgyz Republic” [О условиях и порядке проведения заместительной терапии метадоном в Кыргызской Республике], Order No. 71 (13 March 2001).

\(^\text{885}\) OST is regulated under the following instruments: Ministry of Health, Order “On conditions and procedure of substitution therapy for persons with narcotic addiction in the Kyrgyz Republic”, Order No. 41 (15 February 2001); and the Program of “Substitution therapy with methadone in Bishkek”, approved by this same Order; “Provision on rules and procedures for registration and account of narcological disorders in official bodies of the public health services of the Kyrgyz Republic”, approved by Ministry of Health, Order No. 16 (21 January 2002); “Concept of counteraction to distribution of narcotic addiction and drug trafficking in the Kyrgyz Republic”, approved by the President of the Kyrgyz Republic, Decree No. 445 (22 December 2004).

\(^\text{886}\) During outpatient substitution treatment, patients are obliged to undergo testing for use of psychoactive substances, in order to establish the effectiveness of treatment and to detect any concurrent drug use: Ministry of Health, Order No. 41.
- regular alcohol abuse with signs of alcohol dependence;
- not complying with regularly scheduled visits to the programme, refusal to cooperate with a narcologist or psychologist, or refusal to undergo physical examination;
- commission of a criminal offence and detention pending trial (in which case, a patient may be eligible to receive OST in the penitentiary facilities);
- selling methadone or illicit drugs; and
- aggression toward programme staff.

Each OST patient receives an individual plan of diagnostics and treatment, undergoes testing for hepatitis, HIV, STI and other diseases, and receives treatment of complications and accompanying diseases. Every three months, the facility’s advisory committee assesses the effectiveness of the therapy and develops treatment plan. OST can be carried out on an inpatient or outpatient basis. When OST is provided in outpatient facilities, patients must visit the medical institution daily and receive methadone under the supervision of programme staff. In special cases (e.g., in case of illness of the patient demanding home-based treatment, confirmed by doctor’s certificate), the advisory committee may authorize that methadone be dispensed to a family member in a quantity not exceeding two daily doses.887

In cases when patients receiving OST are hospitalized in other medical and rehabilitation institutions, OST programme administrators are obliged to co-ordinate the procedure of providing the patient with the medicine, in order to ensure effective treatment of accompanying diseases. In this case, delivery of methadone to the patient should be done by medical personnel of the institution in which the patient is hospitalized.

**Compulsory or mandatory drug dependence treatment**

Kyrgyz law authorizes involuntary drug testing in numerous circumstances.

Upon enrolment in certain courses of higher educational institutions, applicants are required to undergo a general physical examination, which usually includes narcological testing. For example, persons applying for enrolment to military schools must pass a physical examination, including proof of absence of narcological disease.888 In high schools, involuntary drug testing is done according to official Government guidelines for detecting drug use by minors.889

In addition, persons applying for a driver’s license are required to undergo a physical examination, including drug testing.890 Drivers of commercial vehicles are allowed to drive after passing an obligatory periodic physical examination based on the procedure established by the Ministry of Health.

Kyrgyz law also provides that compulsory treatment for drug dependence may be carried out by court order in two circumstances.

First, a court may order compulsory treatment for a person diagnosed with drug dependence who avoids voluntary treatment or who continues the non-medical use of drugs after undergoing treatment, in response to an application by relatives to law enforcement bodies or a prosecutor’s office in connection with the person’s dangerous behaviour.891 Such persons are referred for treatment to specialized medical institutions of the public health services; minors older than 16 are sent to specialized medical educational institutions. People with disabilities (of either Category 1 or Category 2 severity, which means more serious disabling conditions), pregnant women and mothers with newborn babies, or persons with serious mental disorder or other serious illness that precludes compulsory treatment, are not subject to compulsory treatment. The duration of compulsory treatment cannot exceed twelve months.892

---

887 Ibid.
888 Ministry of Defence of KR “Instruction on physical examination of students and candidates seeking admission to military schools”, Инструкция по медицинскому освидетельствованию воспитанников военного лицея и кандидатов, поступающих в лицей, No. 199 (9 September 2000).
889 Ministry of Health of KR “Instruction on the order for the preventive medical examination in educational institutions of the Kyrgyz Republic to detect minors consuming narcotic and psychotropic substances” [Инструкция о порядке проведения профилактического медицинского обследования в образовательных учреждениях Кыргызской Республики на предмет выявления несовершеннолетних лиц, допускающих потребление наркотических и психотропных веществ], Instruction No. 468/662/1 (15 November 2002).
890 “Regulation for examinations, issuance to citizens of driver’s licenses and the admission of drivers to driving vehicles”, No. 420 (4 August 1999).
892 This information was reported by the national expert group.
Second, a person convicted of a criminal offence may be ordered to undergo compulsory treatment for drug dependence, in addition to his or her sentence.\textsuperscript{893} If a sentence does not include incarceration, drug dependence treatment takes place in health care institutions. If the sentence does include incarceration, compulsory drug dependence treatment is conducted in the penitentiary. If there is a need after release to continue compulsory treatment, it is provided in general health care facilities. Drug dependence treatment is not provided as an \textit{alternative} to imprisonment, although this is permissible under international law. International drug control treaties explicitly allow States Parties to include, in their domestic legislation, \textit{alternatives} to conviction and incarceration for drug offences, including providing treatment and rehabilitation services, instead of adding these on top of criminal sentences.\textsuperscript{894} There appears, therefore, to be room for Kyrgyzstan to change its current legislative approach of imposing compulsory treatment \textit{in addition to} other criminal punishment, and instead provide for treatment as an alternative. (Treatment must, of course, be in accordance with good, evidence-based clinical standards and with human rights.)

International organizations underline the principle that drug dependence treatment should generally be voluntary.\textsuperscript{895} As a general proposition, compulsory medical treatment violates human rights, including to liberty, security of the person and privacy,\textsuperscript{896} and should be applied only in extreme, clearly defined cases with a view to preventing a person from causing imminent, serious harm to himself or herself or to others. There appears to be a need to tighten current Kyrgyz law to circumscribe more narrowly the bases on which compulsory treatment may be imposed.

More broadly, as the national expert group has recommended, the Government of Kyrgyzstan needs to change the out-dated legislative guidelines, dating back to the Soviet period, that deal with procedures for drug testing, compulsory treatment and the registration of people who use or are dependent on drugs. The national expert group has concluded that there is a need to define a proper legal framework for the prevention, diagnosis and treatment of drug dependence. Therefore, the Government should draft and enact a law specifically dedicated to legal, medical and social measures for reducing drug dependence and the harms associated with drug use. Such legislation should explicitly address measures to ensure access to substitution therapy and should include: guarantees of patients’ rights to voluntary treatment and to give informed consent to treatment; the protection of patients’ confidentiality; and protection against discrimination.

\textbf{Overdose prevention}

According to Government Resolution, the medication naloxone, used to reverse opioid overdoses and prevent them from becoming fatal, is included in the national list of essential medicines in Kyrgyzstan,\textsuperscript{897} making it one of the few countries in the region to do so. This is an important initiative. However, outreach workers of harm reduction programmes are not authorized to administer it or distribute it to people who use drugs and are most likely to be present when it needs to be administered quickly to someone who have overdosed. The national expert group has identified this as an issue requiring attention.

\textbf{4B. HIV PREVENTION AND TREATMENT}

According to Articles 5 and 6 of the \textit{Law “On HIV/AIDS in the Kyrgyz Republic,”}\textsuperscript{898} citizens, stateless persons and foreigners on the territory of Kyrgyzstan are also entitled to:

\begin{itemize}
  \item voluntary, confidential HIV testing and medical supervision in facilities of the public health services;
  \item guaranteed minimum of information on HIV/AIDS and prevention measures;
  \item participation in HIV prevention programmes and access to prophylactics (disinfectants, clean sy-
\end{itemize}

\begin{itemize}

\begin{itemize}
  \item \textsuperscript{893} Criminal Code, Article 90(2). A person may also be ordered to undergo treatment for tuberculosis, venereal diseases or HIV infection (discussed further below).
  \item \textsuperscript{894} Single Convention on Narcotic Drugs, 1961, UN, 520 UNTS 331, as amended by the 1972 Protocol, Article 36(2); Convention on Psychotropic Substances, 1971, UN, 1019 UNTS 175, Article 22; Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances, 1988, Article 3(4).
  \item \textsuperscript{895} UNODC and WHO, Principles of Drug Dependence Treatment: Discussion Paper (March 2008).
  \item \textsuperscript{896} International Covenant on Civil and Political Rights, 999 U.N.T.S. 171 (1966), Articles 7, 9 and 17; Universal Declaration of Human Rights, UN General Assembly Resolution 217A (III), UN Doc. A/810 (1948), Articles 3 and 12.
  \item \textsuperscript{897} Government Resolution “On the List of essential medicines in the Kyrgyz Republic” [Об утверждении Перечня жизненно важных лекарственных средств Кыргызской Республики], No. 759 (31 October 2006).
  \item \textsuperscript{898} Law “On HIV/AIDS”, Law No. 149 (13 August 2005).
\end{itemize}

\end{itemize}
rings, needles and condoms) [emphasis added];
• specialized, qualified medical aid in the field of HIV/AIDS; and
• to receive full information on their rights and on the nature of their health conditions and treatment methods; to qualified legal aid and psychological support; and to the realization of the sexual and reproductive rights.

According to the Law “On HIV/AIDS”, staff of the National AIDS Association, the Ministry of Education and Science, the department responsible for initial vocational training within the Ministry of Labour and Social Development, together with NGOs, carry out health education, including on HIV/AIDS, for general schools and vocational training institutions.

**HIV prevention among people who use drugs**

Needle exchange programmes have operated in Kyrgyzstan for about 10 years; they are generally run by non-governmental organizations. For over five years, needle exchange programmes have existed in the penitentiary system in Kyrgyzstan. Kyrgyz law also allows for the free acquisition of syringes from drugstores.

There is no defined legal framework specifically governing needle exchange programmes, although the NGOs that largely run such programmes have adopted their own internal policies. According to the national expert group, the Ministry of Health should be responsible for drafting, adopting and implementing uniform instructions for operating needle exchange programmes.

Needle exchange programmes include peer outreach workers among their personnel. According to the national expert group, in selecting outreach workers for participation in NSPs, administrators consider a person’s remission period (usually three years abstinence from drug use is required) and their ability to interact with other people using drugs without returning to drug use. In practice, however, according to the expert group, there may be cases where outreach workers can be active users of drugs. The basic services provided by outreach workers include: distributing of sterile syringes/needles, condoms, sterile tampons and disinfectants; motivational interviewing to assist people in connecting to health services, including drug treatment; providing information and educational materials; peer education and training to potential peer educators; and preventing overdoses.

Outreach workers’ activities are not regulated by Kyrgyz law, meaning the standards, rules and conditions of their activity are not defined and there are no guarantees of legal and social protection (which also means outreach workers may bear a risk of liability for their activities). More broadly, as noted above, the national expert group has observed that Kyrgyz law does not provide clear a legal framework for harm reduction programmes, which could put the beneficiaries of services, as well as medical, social and other staff involved in harm reduction services, at risk legally. The national expert group has suggested drafting and adopting a special law devoted to the legal, medical and social security of all actions related to harm reduction.

**HIV testing**

**Voluntary testing**

Kyrgyz law states the general rule that HIV testing is voluntary, done only with written consent of the person being tested.899 Every HIV test should be accompanied by a pre- and post-test psychosocial counselling, performed by medical personnel such as doctors, nurses and social workers.900 According to the Ministry of Health, during pre-test counselling, the test provider is required to give the patient enough time to consider the matters being discussed, check how well the patient understood the information and eliminate misunderstanding, ask the patient whether she or he agrees to take the test, and complete the informed consent form which must be signed by the patient to be valid.901

---

900 Government Order No. 296.
901 Ministry of Health, Order “On approval of new clinical reports”, Order No. 218 (1 June 2005).
Compulsory testing upon request by law enforcement bodies
Under current Kyrgyz law, compulsory HIV testing may be conducted by court order on the basis of an application by the police or public prosecutor; nobody but the police officer who initiated compulsory testing or the public prosecutor has the right to receive the results of the test.

Mandatory testing
Kyrgyz law also provides for mandatory, confidential HIV testing in a number of circumstances.

First, donors of blood and other biological materials are, appropriately, subject to mandatory HIV testing as a condition of donating.

Second, foreign citizens and stateless persons are required to get an HIV test after arrival in the country and during annual preventive medical examinations, if it is stipulated in international treaties binding on the Republic of Kyrgyzstan. In practice, according to the national expert group, this means that foreign citizens are subject to HIV tests only in those cases where Kyrgyzstan has an agreement with the person’s state of citizenship on requiring HIV certificates. Foreigners are subject to administrative deportation from Kyrgyzstan only in the case of deliberately evading obligatory testing. In such a case, the authorities must prove in court that the person maliciously evaded testing and refused or failed to follow the instructions of passport and visa control bodies on testing. The national expert group has noted that if a foreign citizen tests HIV-positive, but did not attempt to evade testing, administrative deportation is not applied. Administrative deportation is enforced by the law-enforcement bodies on the basis of a court decision.

Finally, pre-employment HIV testing is authorized in the case of employees in certain trades and occupations described in an approved government list. This list includes medical workers who perform invasive procedures.

A number of these articles and practices contradict the right to voluntary medical examination for HIV infection, as recognized in Kyrgyz law, and arguably rights that are supposed to be protected by the Constitution, such as freedom from discrimination (see Section 5 below). In addition, according to international standards, an HIV test should be done on a voluntary basis only, except for obligatory tests for donors of blood and organs. If HIV testing is ever to be imposed without consent, then it requires a process clearly set out in law, with a requirement that such measures be taken only in exceptional circumstances and with adequate justification that must be considered by an independent, judicial body, and with the most limited infringement of human rights possible. In addition, the national expert group has expressed concern that involuntary HIV testing risks driving “at risk” groups underground and creating additional barriers to effective HIV prevention and treatment.

HIV treatment
As noted above, the Law “On HIV/AIDS” stipulates access to medical services for persons living with HIV. All kinds of health care services and medicines for Kyrgyz citizens living with HIV are free of charge in the public health care facilities. Citizens living with HIV and AIDS are included in the list of people who have free health care based on their social status. Such free treatment is not available to non-citizens.
According to the national expert group, AIDS centres exist only at the regional level; in rural areas, preventive and medical assistance in relation to HIV/AIDS is performed by family health care centres and family doctors under the supervision of the AIDS centres. There is collaboration between health care facilities which provide treatment for HIV, drug dependence, tuberculosis and hepatitis, including a referral system from one health care facility to another and joint consultations with participation of experts from each involved institution.

According to the national expert group, drug use cannot be a cause for refusing a patient treatment for HIV, hepatitis or tuberculosis. Legislation establishes procedures for providing ARV therapy to HIV-positive people who use drugs.911

**Patients’ rights, including confidentiality**

Patients’ rights are addressed in Chapter IX of the Law “On health protection in the Kyrgyz Republic”, which provides such rights of patients as:

- the right to high-quality medical and sanitary assistance;
- the right to fair and humane treatment;
- the right to testing, prevention, treatment and medical rehabilitation; and
- access to lawyer or other representative for protection of a patient’s rights.

In case such a right is infringed, a patient may file a complaint with the head or another official of the facility, the appropriate professional medical organization or the court.912

By law, the fact of seeking health services, the state of health of a patient, a diagnosis and other information received from a patient through examination and treatment are “medical secrets” which must be kept confidential by health professionals.913 Unauthorized disclosure of medical secret is a criminal offence.

However, disclosing medical secrets without a patient’s consent is allowed in the following circumstances, which are very broad exceptions to confidentiality and give rise to some concern:

- if there is a risk of transmission of infectious diseases or mass poisonings and harm to others;
- upon request by investigative bodies, a public prosecutor or a court;
- in order to inform the parents or lawful representatives of a minor receiving medical assistance; and
- if there are grounds to believe that harm to the health of a person resulted from illegal actions.914

---

911 Ministry of Health, Order “On the approval of new clinical reports”, Order No. 218 (1 June 2005), Section III.
912 Law “On health protection in the Kyrgyz Republic”, Article 72.
913 Ibid., Article 91.
914 Ibid.
5. PRISONS

According to the Penal Code of Kyrgyzstan, correctional facilities include colony-settlements, corrective colonies, educational colonies and prisons. Corrective colonies are divided into colonies of general, strengthened, strict and special security modes. A distinctive feature of Kyrgyzstan’s correctional system is the possibility of private correctional facilities in addition to state facilities.

In implementing the Comprehensive Programme of Development of the Kyrgyz Republic for the period until 2010, the Government is pursuing reforms of the judicial system and law enforcement bodies. Within the scope of this reform, presidential decrees and governmental orders transferred responsibility for the penitentiary system from the Ministry of Internal Affairs to the Ministry of Justice. In 2006, the Ministry of Justice established a Public Supervisory Board for the correctional system. The main functions of the Board are to: improve interaction between NGOs and correctional institutions; develop proposals to bring domestic legislation in line with international human rights standards, and further humanize conditions of serving punishment; and create conditions for the observance of rights and legitimate interests of the staff of the penitentiary institutions, prisoners and persons in pre-trial detention. In June 2007, the President signed the Law directed at “humanizing” the country’s criminal law by abolishing capital punishment and promoting alternatives to incarceration for sentencing, including for drug-related crimes.

Incarceration of people who use drugs

According to the Penitentiary Department of the Ministry of Justice, in 2006, 1679 persons (12.4% of the total prison population) had been convicted of crimes related to drugs. Of these, 986 persons (58.7%) were sentenced to imprisonment, 398 persons (23.7%) to pay a fine, 8 persons (0.5%) to payment of threefold ayip (compensation of damage), 11 persons (0.7%) to public works and “arrest”, and 276 persons (16.4%) to a conditional sentence.

As of 1 October 2007, there were roughly 13,000 people in prison in Kyrgyzstan. Of this total, 1901 persons (approximately 15%) were in prison for drug-related offences. On 1 January 2007, 940 prisoners were ordered to undergo compulsory drug dependence treatment; of these, 191 were people with alcohol dependence and the other 739 were people with dependence on narcotics or psychotropic substances. According to the results of surveys conducted by non-governmental, international organizations and independent experts in Kyrgyzstan’s correctional system, about 35% of prisoners actually use drugs while in prisons (about 50% of whom use drugs by injection).

HIV, drug dependence and other health concerns in prisons

As noted above, in 2006, the penitentiary system registered 21 cases of viral hepatitis, 237 cases of syphilis, 21 cases of gonorrhoea and 41 new HIV infections. As of 1 January 2007, there were 102 prisoners in the country known to be HIV-positive (6 of them receiving ARV therapy). In 2008, the Ministry of Health reported the total number of 178 of prisoners with HIV, including 12 prisoners with HIV/tuberculosis co-infection. Tuberculosis is another significant health concern in Kyrgyzstan’s prisons. In 2006, the country’s correctional institutions detected 532 cases of primary tuberculosis. As of 1 October 2007, correctional institutions had 2483 persons with active forms of tuberculosis on the dispensary account of which 1242 were active TB carriers.


916 President of the Kyrgyz Republic, Decree on “Measures for further improvement of the penitentiary system of the Kyrgyz Republic”, Decree No. 305 (24 October 2001).

917 Government of the Kyrgyz Republic, Order “On procedure and conditions for protection of correctional facilities and conveying prisoners and persons in custody”, Order No. 310 (17 May 2002); Government of the Kyrgyz Republic, Order “On transfer of the penitentiary system of the Ministry of Internal Affairs of the Kyrgyz Republic to the purview of the Ministry of Justice of the Kyrgyz Republic”, Order No. 319 (20 June 2002).

918 Ministry of Justice, Order No. 166 (16 November 2006).


920 Data provided by the national experts [on file].

921 Data provided by the national experts [on file].

922 Data provided by the national expert group [on file].
**Organization of health care in prisons**

The *Penal Code* requires the organization of medical correctional facilities to contain and ensure outpatient treatment of prisoners with HIV, active tuberculosis, or chronic alcohol or drug dependence. Kyrghyz law also provides for the oversight of the correctional system by the public and by NGOs.

In order to coordinate activity in the field of prison health care services, in 2006 the Ministry of Justice established an Information & Analytical Centre on health protection in the correctional system, tasked with collecting statistical information, creating a database and monitoring all programmes and projects in the field of prevention and treatment of socially significant diseases within the correctional system. Preventing HIV and related infections is a major area of attention. NGOs are involved in responding to HIV in prisons; the work with NGOs on HIV prevention in prisons is carried out by the Ministry of Justice and the chief department of the penitentiary on the basis of bilateral agreements, memoranda, within various projects.

In 2006, the Government established a working group for social rehabilitation of prisoners. In addition, in 2007 three ministries jointly created an inter-departmental Council to coordinate the planning, preparation, introduction and monitoring of the *Programme on health protection and social support of prisoners*. The Council is a collective advisory body of representatives of state bodies, international and non-governmental organizations; it defines the strategy for reforming public health services in prisons, co-ordinates the work of health care facilities within the correctional system and promotes creation of a system of social support within the system.

**[Interviews with prisoners about provision of medical services]**

In order to assess the quality of health care services in the correctional system, the national expert group interviewed several prisoners on anonymous basis in August 2007 in Colony-Settlement No. 36 in Bishkek. The sample size was small, but identified some areas of concern that warrant further investigation and attention.

Out of four interviewed respondents, Respondent A relayed that he sought health care treatment for an infectious disease and was hospitalized in the hospital of the penitentiary. He stated that health care staff provided only consultations and diagnostics; medication had to be bought by his relatives and sent from outside the prison.

Respondent B sought medical assistance during incarceration many times and was hospitalized in the Central Hospital of the correctional system for about one month after a drug overdose. Respondent B underwent treatment for drug dependence in the rehabilitation centre “Atlantis” and was not using drugs at the time of the interview. According to the respondent, after many complaints of headaches in the pre-trial facility (SIZO), health care staff gave him only aspirin, analginum and sometimes ascorbic acid. Required medicines for the cold and headache were purchased and delivered by his mother, or if he had money, he purchased them himself.

All respondents said the only difference between health care services in a corrective colony and a pre-trial detention facility is that access to health care workers is easier in a colony than in pre-trial detention centres. In both colonies and pre-trial detention facilities, medicines are often not available or have just run out, meaning all hope rests with relatives. All respondents noted the absence of such experts as dentists, STI specialists, dermatologists and other specialists.

**Drug testing and drug dependence treatment**

At this writing, no special medical correctional facilities exist for prisoners with drug dependence. Under the Ministry of Justice, the Narcological Centre, a division of the Central Hospital of the penitentiary, offers....

923  *Penal Code*, Article 73.
924  Law “On bodies and establishments of the penitentiary system”, Law No. 197 (12 August 2003).
925  *Penal Code*, Article 23(2); Ministry of Justice, Order “On approval of the Statute “On the order of interaction between establishments of the Ministry of Justice of the Kyrgyz Republic with the public, international, religious and other organizations,” Order No. 150 (23 December 2005).
926  Ministry of Justice, Ministry of Health, and State Committee on Migration and Employment, Joint Order No. 131/183-shs/204a (15 September 2006).
927  Order “On Interdepartmental Coordination Council on Health Protection and Social Support in the Penitentiary System” (Межведомственный координационный совет по охране здоровья и социальному сопровождению в уголовно-исполнительной системе), Joint Order of Ministry of Justice No. 49 (25 April 2007), Ministry of Health No. 179 (23 April 2007) and Ministry of Labour and Social Development No. 32 (25 April 2007).
150 beds. The overall objective of the Centre is coordination of treatment and prophylactic assistance to persons with drug dependence, and greater efficiency and better quality of diagnostics, treatment and rehabilitation services for patients.

Voluntary treatment of drug dependence is carried out in the “Atlantis” Rehabilitation Centres, which provide psychological support, restoration of broken social relationships and 12-step programmes for people with alcohol and drug dependence. With support from the Soros Foundation of Kyrgyzstan and the Central Asian HIV/AIDS Programme (CARHAP), “Atlantis” Rehabilitation Centres have been established in seven correctional facilities of the country. The Ministry of Justice has undertaken measures to provide structural change to ensure new methods of work with people with drug dependence, and institutionalization of the Atlantis Rehabilitation Centres.928

According to the national expert group, persons released from prison receive advice on the possibility of continuation of treatment in the civil sector of public health services and their location. Thus, after release people can voluntarily seek treatment.931

According to the national expert group, reforms to the narcological service of the correctional system are being implemented as part of a project on addressing drug use in prisons, which also established a basis for introducing OST in prisons.932 This has included opening a branch for detox and substitution therapy programme in the Narcological Centre of the Central Hospital of the correctional system (in colony #47) and one “Atlantis” Rehabilitation Centre in Jalalabat. In 2006, with support of the AIDS Foundation East-West, a project on social support of persons who are released from the correctional facility was launched at the same institution. The decision has also been made to develop a network of social support services by opening Social Bureaus in nine more correctional facilities and one pre-trial detention facility (with funding from CARHAP). As of August 2008, there was a pilot project of OST in the correctional system in two pre-trial detention centres.

**HIV prevention programmes in prisons, including harm reduction measures**

HIV prevention measures in the Kyrgyz correctional system include:

- provision of information and educational programmes;
- access to HIV testing and counselling;
- needle exchange programmes for people who inject drugs; and
- distribution of condoms in conjugal meeting rooms and in needle exchange programmes.

At this writing, according to the information presented by the national experts, facilities for HIV counseling and testing have been established in five correctional institutions with support from the Global Fund to Fight AIDS, Tuberculosis and Malaria.

Kyrgyzstan has been a leader in the region, and amongst the leaders globally, in implementing needle exchange programmes in prisons. The Ministry of Justice has issued several regulatory acts, allowing distribution in the penitentiary system of the country of information on HIV, needles and syringes, organization on a voluntary basis of self-help groups and peer education services.933 Government regulations

---

928 Ministry of Justice, Order “On organizational measures and staffing,” Order No. 216 (29 December 2006).
930 “Instructions on the terms and conditions for the narcological assistance to persons with mental and behavioural disorders caused by use of psychoactive substances in the penitentiary” (co-coordinated with the Ministry of Health) (24 April 2007), approved by the Ministry of Justice, Order No. 48 (25 April 2007), paras. 2 and 4.
931 Ibid., paras 16 and 19.
932 Project: “Prevention of the use of drugs in prisons”, part of the Program on “Prevention of drug dependence in Central Asia” (CADAP) with support of the European Union and UNDP.
also address such matters as measures of HIV prevention, dissemination of information, establishment of harm reduction programmes. According to the recent amendments to these rules, syringes are no longer forbidden in the correction system of Kyrgyzstan. Needle exchange programmes have been implemented in 10 correctional facilities; as of 2008, there were 14 points where prisoners could gain access to sterile injection equipment. These programmes include not only the provision of sterile equipment, but also the distribution of disinfectants, training on how to reduce risks associated with injection (including HIV risks), individual counselling, information and psychological support to people who use drugs, and consultations with health care staff and referral to testing for HIV, STIs and hepatitis.

**Treatment for prisoners with HIV**

As of January 1, 2007, there were 102 prisoners with HIV, 6 of whom were receiving ARV treatment, 2 other refused or stopped therapy. According to UNODC, data from the Ministry of Health for 2008 indicated there were 178 people living with HIV in Kyrgyz prisons, 12 of whom had HIV/TB co-infection.

According to the Penal Code of the Kyrgyz Republic, not only people with drug dependence are subject to compulsory treatment. People with HIV, active forms of TB, and patients who have not completed the full course of STI treatment, based on the decision of a medical committee of the penitentiary institution, may be ordered by the penitentiary to undergo compulsory treatment.

**Discrimination based on HIV status or drug dependence in prisons**

According to the national expert group, in most respects conditions for HIV positive prisoners are not different from conditions for other prisoners. However, a special feature of the Kyrgyz correctional system is that people living with HIV are housed separately (segregated) from the rest of the prison population. This is contrary to international policy: the *International Guidelines on HIV/AIDS and Human Rights* advise that states should prohibit segregation of HIV-positive prisoners.

Other discriminatory provisions of the penal legislation of Kyrgyzstan include the following:

- Certain categories of prisoners are prohibited from being transferred without an escort or from being temporarily outside prison with authorization. This includes prisoners sentenced to compulsory treatment of alcohol and drug dependence, tuberculosis, venereal disease and HIV-infection.

- In addition, these same categories of prisoners are not allowed to take short-term leave from prison in emergency personal circumstances.

Such restrictions are also contrary to international policy guidance: again, the *International Guidelines* recommend that States should not deny access to privileges and release programmes to prisoners based on HIV status.

---

935 Information presented by the expert group [on file].
936 UNODC, “Kyrgyzstan: General Information”, 2008 [on file].
937 Penal Code, Article 17(3).
938 Ministry of Justice, Order No. 164 (28 October 2003) № 164, in coordination with the State Office of Public Prosecutor, “Regulations for correctional facilities of the Ministry of Justice of the Kyrgyz Republic”.
940 Penal Code, Article 68(2).
941 Penal Code, Article 69(3).
6. DISCRIMINATION AND RESTRICTION OF RIGHTS

Article 13 of the Constitution of Kyrgyzstan stipulates that “all people are equal in the Kyrgyz Republic before the law and the courts and that no person may be exposed to any discrimination or infringement of freedom and other rights based on descent, sex, race [...] or any other circumstances of personal or public character”. The Criminal Code states that it is a criminal offence to violate equality.943

The Law “On HIV/AIDS” also address equality rights of PLHIV. Specifically, it prohibits:

- stigmatizing and discriminating against people living with HIV and people affected by HIV, as well as the infringement of their legitimate interests, rights and freedoms on the ground of HIV-infection;
- refusing to hire someone or terminating a person’s employment, except for certain kinds of professional positions established by a special list;
- refusing to enrol someone in an educational institution or accept a person as a patient in a health care facility.944

These are welcome provisions. However, there remain aspects of Kyrgyz law that are of concern, in that they unjustifiably discriminate on the basis of HIV status or drug dependence.

**Discrimination based on HIV status or drug dependence**

One issue that remains of concern is the denial of family rights to persons living with HIV. Currently, persons with “serious chronic infectious diseases” cannot adopt children under Kyrgyz law.945 Yet HIV status is not in itself a sufficient justification to deny equal treatment in adoption; rather, as with all such cases, the individual circumstances and ability of the potential parent must be assessed, with the consideration of the best interests of the child in mind. Misinformation and prejudice about HIV and PLHIV cannot be allowed to disentitle a person from adopting on this basis.

The review by the national expert group also identified discrimination against people who use drugs as an area of concern, given the objective of strengthening HIV prevention and care among this vulnerable population. The expert group’s analysis suggested that Kyrgyzstan’s legislation has provisions that need to be revised, primarily due to the fact that they themselves stigmatize and discriminate against people who use drugs. Examples include the following:

- **Discrimination in employment:** People who use drugs are prohibited from certain kinds of employment, in which mandatory drug testing is also imposed as part of the recruitment process (e.g., law-enforcement and drug control bodies, Office of the Public Prosecutor). If a medical commission finds that the person is not eligible based on health status (including drug use), recruitment is terminated.

- **Discrimination in family relations:** People with dependence on drugs or alcohol are prohibited from adopting children; there is no time limit on this prohibition specified in the law.946 Adoption of a child can be considered void if adoptive parents do not perform parental duties; abuse their parental rights; engage in cruel treatment of adopted children; or are chronically dependent on alcohol or drugs.947 Furthermore, in cases of concern about child abuse or neglect, **chronic drug dependence** may be an aggravating factor that is per se a basis for depriving parents of custody of a child, along with such other grounds as abuse of parental rights, cruel treatment and committing...

---

943 Criminal Code, Article 134: “Direct or indirect infringement or restriction of the rights and freedom of the person and the citizen [...] is punished by a fine or corrective works for a term up to two years. The same act made with use of office status, is punished by a higher fine or imprisonment for a term up to two years.”


945 Government Resolution [положение] “On rules of transfer of children who have remained without care of parents, on adoption to citizens of the Kyrgyz Republic, and foreign citizens” [Положение о правилах передачи детей, оставшихся без попечения родителей, на усыновление (удочерение) гражданам Кыргызской Республики, а также иностранным гражданам], Resolution No. 121 (22 February 2006).

946 Ibid.

947 Family Code of the Kyrgyz Republic, Law No. 201 (30 August 2003), Article 147.
a deliberate crime against the life or health of children. Automatic assumptions that the health condition of alcoholism or drug dependence should warrant removal of a child is unjustifiable. Any deprivation of parental rights should be based on individualize assessments in the circumstances.

Currently, Kyrgyz law does not contain any provisions protecting people who use or are dependent on drugs from discrimination; it has only general provisions on protection against discrimination, which are insufficient in the light of identified patterns of discrimination, including against vulnerable groups such as people who use drugs, whose stigmatization and marginalization only impedes effective responses to HIV. According to the national expert group, the rights of people who use drugs are regularly infringed, including such things as: enforcement of compulsory medical testing and treatment; drug user registration and associated breaches of confidentiality; excessive measures of administrative and criminal punishment; the deprivation of parental rights; refusal to grant medical and social services and legal aid, etc.

In the estimation of the national expert group, a main reason for discrimination against people who use drugs is their continued criminalization. Current Criminal Code provisions, which cast all people who use drugs as criminals or potential criminals, contribute to the stigmatization of people who use drugs. Revisiting the approach that relies predominantly on criminalizing and punishing people for drug use is therefore necessary.

In addition, the national expert group has recommended enacting a law on narcological assistance and providing mechanisms for protecting patients against stigmatization and discrimination, including supporting and protecting those suffering from infringements of rights through illegal actions by government bodies.
7. RECOMMENDATIONS FOR LEGISLATIVE AND POLICY REFORM

In order to strengthen the response to HIV among people who use drugs and in prisons, the national expert group has recommended two things in particular: eliminating discriminatory provisions in Kyrgyz and providing appropriate financing of programmes that are adopted.

According to the national expert group, those populations vulnerable to HIV are also among the most marginalized populations in Kyrgyzstan. Much of the public, and many politicians and government representatives, view these groups as engaged in immoral activities and unworthy of protection and support. According to the national expert group, these attitudes are partly rooted in the ideological and legal trends towards rigid and repressive criminal and administrative policy and state compulsion of the Soviet period. Those who suffer most from such an emphasis on punitive methods for dealing with what are primarily health issues are those who are further marginalized by such inefficient and ineffective government policies and made more vulnerable to poor health and to human rights abuses as a result. The ostensible struggle against drugs has too easily become a programme of targeting people who use drugs for repression and punishment.

As the national expert group has noted, it is time to assess the reforms in 2007 to Kyrgyzstan’s criminal law in the area of drugs. To their credit, in partly liberalizing the country’s drug policy, the government and legislators have sought to mitigate punitive measures for people who use drugs or are drug-dependent. However, these reforms have been insufficient and not carried out consistently; further work, including further legislative reforms to further humanize Kyrgyz drug policy, is needed to avoid ongoing violations of human rights and to be more effective in addressing the health-related harms of drugs, including HIV. In the view of the national expert group, the Criminal Code amendments should have led to changes in enforcement of the law as well, but these have not been fully realized, as a result of deeply-rooted repressive tendencies, corruption, the absence of effective civilian oversight and, most importantly, the ongoing approach, inherited from the Soviet period, in which data about prosecutions and convictions is seen as the main indicator of “progress” in tackling the drug problem. This leads to situations where law enforcement staff can fabricate evidence by planting drugs and psychotropic substances, force self-incrimination or involve drug users in selling drugs. Such police practices undermine efforts to humanize the system through legislative reform.

According to the national expert group’s assessment, the main goal of further reforms should be to move further away from criminal and administrative penalties as the primary approach to drugs and people who use them, and instead focus on the development of evidence-based programmes to prevent drug dependence, to treat people with drug dependence and to prevent or reduce harms associated with drug use, including HIV. In order to achieve more effective and longer-term solutions to problem drug use and related harms, the national expert group proposes to develop a new national drug policy with an emphasis on prevention, treatment and harm reduction, and an avoidance of repressive measures against people who use or are dependent on drugs. Further humanization of criminal and administrative provisions related to drug offences is required, with a view to achieving full depenalization of manufacturing, acquisition, possession, transportation or mailing of narcotic drugs and psychotropic substances without an intention to sell. It is also recommended that Kyrgyzstan reform its legislation to provide greater opportunities for alternatives to imprisonment, and that the government should also introduce non-compulsory treatment for drug dependence as well as enhanced services providing informed education aimed at preventing problem drug use and medical and social rehabilitation and reintegration of people who use drugs.

Among other shortcomings of the current situation with human rights of people who use drugs and prisoners in Kyrgyzstan, particularly noteworthy is the need for greater respect and protection for confidentiality, as well as ensuring access to information and that medical testing (including drug testing or HIV testing) is fully voluntary. Discrimination against people living with HIV/AIDS and members of vulnerable groups (such as people who use drugs) undermines access to health services and the effective implementation of preventive measures. The national expert group has noted the importance of legislatively binding guarantees regarding rights of the patient to treatment, informed consent and confidentiality of HIV tests, access to substitution therapy and protection from stigmatization and discrimination.
More detailed recommendations for reforms in these and other areas are listed below. The recommendations presented here are aimed at addressing issues identified by the national expert group of Kyrgyzstan and by the project's technical advisors. Suggested language of legislative amendments is shown in shaded boxes.

**National Programmes and Strategies**

**Recommendation 1: Ensure the effectiveness of the national response to HIV and narcotic drugs**

In order to increase the effectiveness of current national programmes on HIV/AIDS prevention and narcotic drugs, the national expert group has recommended the following:

- increased financing of programmes;
- a clear definition of responsibilities of authorized bodies;
- develop national programmes for the prevention of STIs and hepatitis.

**Recommendation 2: Develop a national drug policy with emphasis on public health**

The national expert group has recommended developing a new national drug policy that emphasizes preventing drug misuse and preventing or reducing harms associated with unsafe drug use, while removing the emphasis on punitive and repressive measures against persons who use drugs (including those who are drug-dependent).

**Administrative and criminal law issues**

**Recommendation 3: Remove intoxication as aggravating factor for criminal liability**

According to the *Administrative Code* (Article 43) and *Criminal Code* (Article 55(16)), being intoxicated by drugs or alcohol while committing a crime is an aggravating circumstance. However, whether or not a person is intoxicated does not affect the gravity of the harm of his or her crime, so it should not be considered as making the crime more serious. Rather, such a provision effectively discriminates against people accused of offences based on their health status (i.e., dependence of drugs or alcohol), imposing harsher penalties for a given offence on people with this health condition. Article 43 of the *Administrative Code* and Article 55(16) of the *Criminal Code* should be repealed.

**Recommendation 4: Remove criminal and administrative liability for possession of small quantities of drugs for personal consumption**

The national expert group has suggested the Government should continue the initiative of “humanizing” the country’s criminal and administrative laws dealing with drugs, with a view to achieving the full depenalization (i.e., neither criminal nor administrative penalty) of manufacturing, acquisition, possession, transportation or transfer of small amounts if narcotic or psychotropic substances without intention to sell. To this end, a number of steps should be taken.

(1) Currently, the *Administrative Code* (Article 366) appears to penalize even the mere use of narcotics or psychotropic substances. This should be repealed.

(2) One of the recommendations of the expert group is to define legislatively the concept of “personal

---

948 In many instances, the wording of proposed legislative amendments is adapted from model provisions in *Legislating for Health and Human Rights: Model Law on Drug Use and HIV/AIDS* (Toronto: Canadian HIV/AIDS Legal Network, 2006), online in both English (www.aidslaw.ca/modellaw) and Russian (www.aidslaw.ca/modellaw-ru). This publication, consisting of a series of 8 modules on different issues, was used as a key reference by UNODC, national expert groups and the project’s technical advisors during the review and assessment of national legislation in the countries participating in the project. Where relevant, citations below are to specific modules of that resource; the accompanying text and commentary to be found in those modules may be useful to legislators and policy-makers in implementing these recommendations.
consumption” and to provide alternatives to punishment for cases of acquiring and possessing controlled substances in a quantity intended for personal consumption, such as education and, where clinically indicated, treatment and medical and social rehabilitation. In implementing reforms to remove criminal and administrative liability for possession of quantities for personal use, the Government should enact a provision such as the following in a statute such as the Law “On narcotic drugs, psychotropic substances and precursors”, the Administrative Code or the Criminal Code (or all three).949

Decriminalization [depenalization] of possession without intention to sell

Notwithstanding anything in this or any other statute, the possession and use of a [small quantity] of a narcotic or psychotropic substance listed in [relevant schedule/list] for personal use does not constitute a criminal or administrative offence.

(3) Removing penalties for activities involving quantities of drugs for personal use, including possession, also requires attention to the approach to how quantities of drugs are defined for purposes of administrative or criminal liability. In this regard, Kyrgyz law could be improved, so as to reflect real-world circumstances of drug use. To that end, Governmental Order of the Kyrgyz Republic No. 543 (9 November 2007) should be amended as follows:

- A quantity for “personal consumption” should be defined by reference to the known frequency of use on a daily basis and the quantity consumed per instance of use, although it would be a mistake to limit it too strictly to just a certain specified number of daily doses, as a person may possess a quantity for his or her use over several days.

- The national expert group also recommended defining the lower limit of the “small quantity” of narcotics, which at the moment is zero. The Government Order defining different quantities of drugs for administrative and criminal law purposes establishes only the upper limit of the “small quantity” [небольшие размеры] of various narcotic drugs and psychotropic substances, and does not define the lower limit of this category to reflect minimal amounts. In other words, the legal category of “small” quantity" includes any quantity, however minimal. In addition to penalizing people who use drugs and therefore possess even minimal quantities, this measure also creates potential liability for even residual amounts of narcotics, such as that found in a used syringe — this creates an incentive for people who use drugs to dispose of used syringes quickly and unsafely, rather than returning them to needle exchange programmes, and also means that outreach workers and other staff of needle exchange programmes are exposed to liability for possession.

- Finally, in defining various quantity ranges of different drugs, the law should make clear that this is a reference to a quantity of the pure drug itself, not the quantity that includes other fillers or additives that may be mixed with it.

Recommendation 5: Provide alternatives to imprisonment for some drug offences and establishing an extra-judicial Commission

The national expert group has recognized that one important measure of HIV prevention will be to reduce the frequency with which people who use drugs go to prison. Implementing Recommendation 4 above is one important way to achieve this, by removing criminal liability at least in the case of possession of small quantities of drugs for personal use.

In addition to taking such a step, to the extent that certain acts related to drugs remain criminal offences, at least the approach to punishing such crimes can be changed to reduce the use of imprisonment, with all the human and financial costs and harm to public health that imprisonment carries. The national expert group has recommended amendments to the Criminal Code to implement alternatives to imprisonment for non-violent offences related to drugs (without an intention to sell).

The national expert group has recommended legislation to establish a Commission to deal with cases connected with illegal manufacturing, acquisition, possession, transportation or transfer of narcotics or psychotropic substances in a small quantity without intention to sell. A legislative provision such as the following, inserted into a statute such as the Law “On narcotic drugs, psychotropic substances and precursors” or the Criminal Code, could create the legal basis and mandate of the Commission:

**Alternatives to prosecution and imprisonment for certain drugs offences**

**Option 1: Referral to quasi-judicial commission**

(1) The sections below apply to the following offences involving a narcotic or psychotropic substance when those offenses are committed in circumstances that do not involve violence and there is no accusation of an intent on the part of the accused to sell said substance: i.e. under Articles 91-2 and 366 of the Code of the Republic of Kyrgyzstan on Administrative Responsibility, and Article 43 of the Criminal Code:

(a) Illegal possession, transportation or transfer of narcotics or psychotropic substances without an intention to sell and in a “small quantity” [небольшие размеры]
(b) The “use of narcotics or psychotropic substances, the consumption of alcohol in the streets, stadiums, parks, in public transport and in other public places, or appearing in public in a state of intoxication that offends human dignity and social morality”
(c) Being intoxicated by alcohol or a narcotic or psychotropic substance while committing an administrative offence

(2) The offences referred to in section (1) shall be processed, and penalties applied if applicable and necessary, by a quasi-judicial commission (“the Commission”).

(3) The Commission shall include a legal expert, as well as other experts such as medical practitioners, psychologists, social service workers or others with appropriate expertise in the field of drug dependence.

(4) The rules of procedure governing the proceedings of the Commission, including the admissibility of medical evidence, shall be determined by the Ministry of Justice and the Ministry of Health.

(5) In arriving at the appropriate penalty for a person apprehended by police for the offences referred to in Section (1), the Commission shall consider:

(a) the seriousness of the act;
(b) the relative degree of fault;
(c) the type of substance involved in the offence;
(d) the public or private nature of the offence and, if relevant, the location of the offence;
(e) the personal circumstances, namely economic and financial, of the offender; and
(f) whether the offender is an occasional, habitual or dependent drug user.

(6) The Commission may apply penalties including, but not limited to, one or more of the following:

(a) a notice of caution;
(b) a fine in proportion to the amount of the narcotic or psychotropic substance possessed for personal use, taking into account the economic situation of the alleged offender;
(c) restriction on travel or attendance in certain places; and
(d) suspension of driving or professional licences.

(7) The penalties applied by the Commission shall not include custodial penalties.

(8) If the person apprehended for the offences referred to in Section (1) is found by the Commission to be dependent on a narcotic or psychotropic substance, the Commission may order that the

---

950 Note that it will be important to avoid an order that prohibits the person from entering an area where important health services (e.g., needle and syringe programs, health clinics, etc) are located.
person attend a specified number of meetings with the provider of a drug dependence treatment programme, the purposes of which shall be to ensure the person is aware of the programme’s services that may assist in overcoming drug dependence and to determine whether the person wishes to avail himself or herself of the services of the programme. The Commission may not compel the person to undergo drug dependence treatment.

Another option for creating alternatives to imprisonment could be achieved by enacting the following provision:

**Option 2: Non-custodial sentencing measures**

(1) Notwithstanding the provisions of this or any other statute, where
   (a) a person is found guilty in a court of law of the offence of possession of a narcotic or psychotropic substance contrary to the law;
   (b) in the court’s opinion, taking into account the quantity of the substance possessed and all other relevant circumstances of the case, the use or possession of a narcotic or psychotropic substance was for the purpose of personal use; and
   (c) the applicable sentence would ordinarily include a custodial sentence;

a court shall, rather than imposing a custodial sentence, order one or more of the following:

   (a) direct that the person be discharged absolutely or on the conditions prescribed in a probation order;
   (b) suspend the passing of sentence and direct that the person be released on the conditions prescribed in a probation order;
   (c) fine the person, if the court is satisfied that the person is able to pay the fine;
   (d) order that the person serve the sentence through community service, subject to the person’s complying with the conditions of a conditional sentence order; or
   (e) make a supervised attendance order with the consent of the person requiring him or her to attend a place of supervision for such time as is specified in the order and, during that time, to carry out such instructions as may be given to him by the supervising officer within the lawful exercise of that officer’s authority.

(2) As a term of a probation order or a conditional sentence order in Section (1), the court may order that the person attend a specified number of meetings with the provider of a drug dependence treatment programme, the purposes of which shall be to ensure the person is aware of the programme’s services that may assist in overcoming drug dependence and to determine whether the person wishes to avail himself or herself of the services of the programme. The court may not compel the person to undergo drug dependence treatment.

(3) The court may make an order as described in Section (1) if the court considers it to be in the best interests of the accused and not contrary to the public interest, having regard to the age and character of the offender, the nature of the offence and the circumstances surrounding its commission. In making such a determination, the court shall consider the results of any clinical assessment that may have been made of the person.

**Recommendation 6: Preclude criminal or administrative liability for harm reduction programmes**

In order to ensure they are most effective in advancing their mandate of protecting and promoting health, the harm reduction and outreach activities of non-governmental organizations targeting people who use drugs, such as programmes providing sterile syringes or other equipment to reduce harms associated with drug use (including HIV transmission), should be clearly exempt from possible legal liability. To this end, the national expert group has recommended a legislative amendment to add the following text to Article 249 of the *Criminal Code* (specifically in relation to the offence of “inducing consumption”):
The present article does not apply to cases of distributing information aimed at preventing infection with HIV or other infectious diseases among people who use narcotic or psychotropic substances or the distribution of corresponding tools and equipment for this purpose.

It is suggested that this recommendation should also extend to other aspects of the law creating a similar risk of legal liability, which aspects should be addressed in a similar fashion. In particular, harm reduction programmes also should be clearly exempt from liability for “organization or maintenance of sites” for the consumption of drugs (Criminal Code, Article 252). Wording such as the proposal above could easily be added to these other existing provisions as well, to achieve the same effect.

**Recommendation 7: Limiting compulsory drug testing in the law**

According to the information presented by the national experts and described above, currently, compulsory testing is conducted mainly following referral by police, in cases where police suspect illegal activities. While this is a very broad application of compulsory testing, Article 36 of the Law “On narcotic drugs, psychotropic substances and precursors” also includes other, broadly-worded provisions. Yet compulsory drug testing violates privacy and security of the person, without justification in most circumstances, since merely showing past use of drugs does not prove there is a serious risk of harm to self or others, which should be the only basis for possibly justifying an intrusion by the state into such rights. Furthermore, the national expert group has raised the concern that this very broad power of police to compel people to undergo drug testing simply based on police suspicions of a crime opens the door to police abuses, including extortion. To eliminate unjustifiably broad provisions for compulsory drug testing, it is recommended that, at the least, Article 36 of this law to specify that “compulsory drug testing is possible only following a court order.”

**Recommendation 8: Eliminate HIV and STI-specific criminal law**

Articles 117 and 118 of the Criminal Code, which specifically provide liability for transmission and exposure to “venereal diseases” and HIV, should be repealed, in line with international policy recommendations. In the case of intentional transmission of venereal or HIV infection, this could be dealt with as infliction of bodily harm that is covered by other articles of the Criminal Code.

**Health care**

**Recommendation 9: Revisit operation of drug user registry**

The current system of registration of drug users is one factor that discourages people from seeking medical treatment, including for drug dependence, and may provide a basis for various infringements of confidentiality. It is therefore recommended that the government begin an assessment of the efficacy and cost-effectiveness of the current approach. Article 36(3) of the Law “On narcotic drugs, psychotropic substances and precursors” should be repealed.

**Recommendation 10: Limit the use of compulsory treatment of drug dependence**

Articles 40 of the Law “On narcotic drugs, psychotropic substances and precursors” on drugs specifies who may be referred to compulsory treatment flowing a court decision: a) people recognized as having drug dependence, but who evade treatment, or people who have continued to use drugs after treatment; and b) people in relation to whom police have received an application from relatives based on the person’s “dangerous behaviour.” International organizations underline the principle that drug dependence treatment should generally be voluntary. As a general proposition, compulsory medical treatment violates human rights, including to liberty, security of the person and privacy, and should be applied only in accordance with the requirements of necessity and proportionality.\(^{952}\)
extreme, clearly defined cases with a view to preventing a person from causing imminent, serious harm to himself/herself or to others. It is recommended that Article 40 be clarified and narrowed by rewording it to authorize compulsory treatment of drug dependence only in cases where there is a significant risk of serious harm to oneself or others.

Recommendation 11: Protect confidentiality, improve access to voluntary drug dependence treatment

The national expert group has recognized that notwithstanding general statements in the law about protecting confidentiality of patients’ health information, there are infringements of said confidentiality. Concern about loss of confidentiality, including providing information to law enforcement that can result in prosecution for administrative or criminal offences, is an obvious disincentive to seeking treatment. The national expert group has recommended that the government organize and support a network of sites providing greater access to drug dependence treatment that is voluntary, free and anonymous.

In addition, for people receiving drug dependence treatment, there are unjustifiably broad exceptions in current Kyrgyz law to the general requirement of maintaining medical confidentiality of patients — including disclosure of patient information to law enforcement bodies upon request. The experts note that confidentiality of medical information, including information about narcological diagnosis in Kyrgyzstan is too frequently disregarded. To protect confidentiality better, legislative provisions such as the following should be added to the Law “On narcotic drugs, psychotropic substances and precursors” and/or to the new law on drug dependence prevention and treatment recommended by the national expert group (see Recommendation 12 below):

Confidentiality of patients’ information

(1) The confidentiality of all health care information shall be respected. Records of the identity, diagnosis, prognosis or treatment of any patient which are created or obtained in the course of drug dependence treatment:
   (a) are confidential;
   (b) are not open to public inspection or disclosure;
   (c) shall not be shared with other individuals or agencies without the consent of the person to whom the record relates; and
   (d) shall not be discoverable or admissible during legal proceedings.

(2) No record referred to in Section (1) may be used to
   (a) initiate or substantiate any criminal charges against a patient; or
   (b) act as grounds for conducting any investigation of a patient.

(3) Programme staff cannot be compelled under the Criminal Code or any other law to provide evidence concerning the information that was entrusted to them or became known to them in this capacity.

(4) All use of personal information of patients and programme staff in research and evaluation shall be undertaken in conditions guaranteeing anonymity, and any such information shall also be governed by Section (2) of this article.

Recommendation 12: Adopt a new law on drug dependence prevention and treatment

The national expert group has recommended that Kyrgyzstan draft and adopt a new Law “On drug dependence prevention and treatment”, which would provide a legal basis and guarantees of safety for the activities of medical staff, social and outreach workers, their rights and duties, and mechanisms for the protection of the rights of patients from stigmatization and discrimination. After the law is drafted it is recommended to remove relevant articles and the chapter on drug dependence treatment from the Law General Assembly Resolution 217A (III), UN Doc. A/810 (1948), Articles 3 and 12.
“On narcotics, psychotropic substances and precursors” (Chapter VI) that references prevention and treatment of drug dependence. All questions connected with prevention and treatment of drug dependence treatment would be found in the separate law directed at prevention of dependence and reducing harms associated with drug use (e.g., prevention of HIV among other things).954

Whether in a new law on drug dependence treatment or by amendment to existing legislation, the government should include provisions such as the following to ensure drug dependence treatment is done in accord with good practice and human rights norms:

<table>
<thead>
<tr>
<th>Basic rights of patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>Every patient has the right:</td>
</tr>
<tr>
<td>(a) to a full course of high-quality treatment and follow-up support to be provided in accordance with good clinical practice;</td>
</tr>
<tr>
<td>(b) to treatment without discrimination;</td>
</tr>
<tr>
<td>(c) to meaningful participation in determining his or her own treatment goals, which may include but are not limited to abstinence or changes in drug use that minimize the harms of dependence;</td>
</tr>
<tr>
<td>(d) to meaningful participation in all treatment decisions, including when and how treatment is initiated and withdrawal from treatment;</td>
</tr>
<tr>
<td>(e) to exercise his or her rights as a patient, including:</td>
</tr>
<tr>
<td>(i) reporting, without retribution, any instances of suspected abuse, neglect, or exploitation of patients in the programme;</td>
</tr>
<tr>
<td>(ii) a grievance and appeal process, in accordance with national laws and regulations;</td>
</tr>
<tr>
<td>(iii) input into the policies and services of drug dependence treatment programmes; and</td>
</tr>
<tr>
<td>(iv) voluntary withdrawal from treatment at any time.</td>
</tr>
<tr>
<td>(f) to confidentiality of medical records and clinical test results; and</td>
</tr>
<tr>
<td>(g) to be fully informed, including but not limited to the right to receive information on:</td>
</tr>
<tr>
<td>(i) his or her state of health;</td>
</tr>
<tr>
<td>(ii) his or her rights and obligations as a patient, as specified in this Part and in applicable law;</td>
</tr>
<tr>
<td>(iii) the procedure for making a complaint about the services received through the programme; and</td>
</tr>
<tr>
<td>(iv) cost and payment conditions and the availability of medical insurance and other possible subsidies.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Informed consent</th>
</tr>
</thead>
<tbody>
<tr>
<td>(1) Informed voluntary consent of a patient is a necessary preliminary condition for medical treatment or a preventive or diagnostic intervention.</td>
</tr>
<tr>
<td>(2) The following are the elements required for consent to treatment:</td>
</tr>
<tr>
<td>(a) the consent must relate specifically to the treatment administered;</td>
</tr>
<tr>
<td>(b) the consent must be fully informed;</td>
</tr>
<tr>
<td>(c) the consent must be given voluntarily;</td>
</tr>
<tr>
<td>(d) the consent must be provided in writing; and</td>
</tr>
<tr>
<td>(e) the consent must not be obtained through misrepresentation or fraud.</td>
</tr>
<tr>
<td>(3) A consent to treatment is fully informed if, before giving it:</td>
</tr>
<tr>
<td>(a) the person received the information about the matters set out in Section (4) that a reasonable person in the same circumstances would require in order to make a decision about the treatment; and</td>
</tr>
<tr>
<td>(b) the person received responses to his or her requests for additional information about those matters.</td>
</tr>
<tr>
<td>(4) The matters referred to in Section (3) are:</td>
</tr>
</tbody>
</table>

954 For more detailed model statutory provisions for a new law on drug dependence treatment, see Legislating for Health and Human Rights: Model Law on Drug Use and HIV/AIDS (Toronto: Canadian HIV/AIDS Legal Network, 2006), and in particular Module 2: Treatment for drug dependence.
2. The expected benefits of the treatment.
3. The material risks of the treatment.
4. The material side effects of the treatment.
5. Alternative courses of action.
6. The likely consequences of not having the treatment.

**Withdrawal from treatment**

(1) A patient shall have the right to withdraw voluntarily from treatment at any time.

(2) The health practitioner shall fully inform the patient of the potential risks and benefits of withdrawal from treatment and shall work with the patient to ensure the patient’s safety and comfort during the withdrawal process.

(3) The health practitioner shall not discontinue services that are needed unless the patient requests the discontinuation, alternate services are arranged, or the patient is given a reasonable opportunity to arrange alternate services.

(4) The withdrawal from treatment with an explanation of likely consequences shall be recorded or registered in medical documentation and signed by the patient and health practitioner.

(5) Involuntary withdrawal from treatment shall be avoided except where compelling reasons exist. Regulations governing grounds for involuntary withdrawal shall be clearly communicated to patients at the outset of treatment.

**Recommendation 13: Address overdose among people who use drugs**

According to the information presented by the experts, Kyrgyzstan is one of the few countries of the region where naloxone is included in the national list of essential medicines. However, even in Kyrgyzstan this medicine is not allowed to be distributed by outreach workers. The national expert group has recommended that medical personnel and outreach NGO workers receive training in diagnosing and providing emergency treatment for overdose. Consideration should also be given to making naloxone, and information on its use to reverse overdoses, available to outreach workers from harm reduction programmes and to people who use opioids or whose acquaintances are at risk of overdose.

**Recommendation 14: Developing legal regulation of outreach work**

According to the national expert group, the activities of outreach workers are not legally regulated, meaning the standards, rules and conditions of their activity are not defined, nor are there guarantees of legal and social protection, putting them at risk of legal liability. Some legislative provisions that could usefully address this concern are as follows:

**Outreach to people who use drugs**

(1) "Outreach work" means a community-oriented activity undertaken to contact and provide information and services to individuals or groups from particular populations at risk of blood-borne diseases, particularly those who are not effectively contacted or reached by existing information and services or through traditional health care channels.

(2) "Outreach workers" include paid social or public health workers or unpaid volunteers (including peers) of governmental or non-governmental facilities.

(3) Outreach workers may include people who currently use drugs, people who formerly used drugs or people who do not use drugs and are trusted by people who use drugs.
Supply of information

Outreach workers may provide information including, but not limited to, the following:

(a) drug dependence treatment services and other health services;
(b) means of protection against transmissible diseases, including blood-borne diseases such as HIV;
(c) the risks associated with the use of controlled substances;
(d) harm reduction information specific to the drug being used, including safe injecting and inhalation practices;
(e) legal aid services;
(f) employment and vocational training services and centres; and
(g) available support services for people with drug dependence and their families.

Supply of material

Outreach workers may provide the following materials:
(a) sterile syringes and other related material for safer injection drug use, including sterile water ampoules, swabs, filters, safe acid preparations, spoons and bowls and other appropriate materials;
(b) material to enable safer smoking and inhalation of drugs, such as pipes, stems, metal screens, alcohol wipes and lip balms;
(c) condoms and other safer sex materials such as water-based lubricants and dental dams, as well as information about reducing the risks of HIV and other sexually transmitted infections; and
(d) first aid in emergency situations.

Exemption from criminal and civil liability for outreach work

(1) The Law “On narcotic drugs, psychotropic substances and precursors” does not prevent the giving of advice, information or instruction for safer drug consumption practices by outreach workers nor does it prohibit the sale or supply of syringes and other related material by outreach workers.

(2) A civil proceeding cannot be brought against any person (including the state or outreach staff) in relation to any act or omission in connection with outreach work, if the act or omission was in good faith for the purpose of executing this Part and was not a reckless or negligent act or omission.

Recommendation 15: Limit the use of involuntary HIV testing

If HIV testing is ever to be imposed without consent, then it requires a process clearly set out in law, with a requirement that such measures be taken only in exceptional circumstances and with adequate justification that must be considered by an independent, judicial body, and with the most limited infringement of human rights possible.955

The Law “On HIV/AIDS” currently provides for mandatory HIV testing for blood, organ and tissue donors; foreigners and stateless persons when provided by international bilateral agreement; and people occupied in specific professions, defined by a special list (adopted by the Government of Kyrgyzstan).956 According to international standards, mandatory HIV testing is justified only in case of blood, organ or tissue donors. Thus, the Law “On HIV/AIDS” should be amended to prohibit obligatory HIV testing except in such cases, and should explicitly prohibit mandatory testing as an employment requirement or as a residence/entry requirement for foreigners or stateless persons. Adding a legislative provision such as the following would be advisable:

---

955 Guidelines such as the UN’s Siracusa Principles on permissible limitations on human rights should be complied with in any legislative provision that would allow involuntary testing or treatment: UN Economic and Social Council, Siracusa Principles on the Limitation and Derogation Provisions in the International Covenant on Civil and Political Rights, UN Doc. E/CN.4/1985/4, Annex (1985).

Voluntariness of HIV testing

(1) Every person is entitled to free confidential [or anonymous] testing for infection with HIV, other blood-borne infections or other sexually transmitted infections, and to counselling in connection with such testing.

(2) No test for HIV, other blood-borne infection or other sexually transmitted infection shall be undertaken except with the informed voluntary consent in writing of the person being tested.

(3) All persons presenting themselves for testing shall be offered pre-test and post-test counselling by a health practitioners, in accordance with professional standards.

Prisons

Recommendation 16: Develop and monitor indicators on drug use in prisons

The national expert group has recommended establishing a working group of employees of the correctional system of Kyrgyzstan to develop indicators for the regular collection of the information on prevalence of drug use among prison population.

Recommendation 17: Provide information about HIV prevention in prisons

To enhance HIV prevention efforts in prisons, the Internal Regulations of correctional facilities\(^\text{957}\) (para. 3) should be amended to mandate that newly arrived prisoners receive information on HIV prevention and treatment during the first several days of stay in prison.

Recommendation 18: Voluntary drug dependence treatment in prisons

As part of an effective response to HIV and otherwise promoting the health of prisoners, Ministry of Justice, in collaboration with the Ministry of Health and with non-governmental organizations should draft and adopt an "Instruction on the procedure and conditions of free narcological assistance in the correctional system."

Recommendation 19: Limit application of compulsory medical treatment in prisons

In order to better protect human rights, it is recommended to review provisions on compulsory treatment in prisons. The Penal Code provides, that compulsory treatment is applied to those with drug dependence, HIV infection, active tuberculosis, and those who have not completed a full course of treatment of a venereal disease. The scope of compulsory treatment should be narrowed.

Recommendation 20: Eliminate discrimination against HIV-positive prisoners, including segregation, and against prisoners with drug dependence

Current Kyrgyz law includes a number of provisions that unjustifiably discriminate against prisoners based on HIV-positive status and/or drug dependence. To eliminate such discrimination, the following amendments to the Penal Code are required:

- Article 68 of the Penal Code of the Kyrgyz Republic prohibits movement without an escort or convoy outside the protected territory for a number of categories of prisoners, including those who have not finished complete course of compulsory treatment of alcohol or drug dependence, open...
form of tuberculosis, STI or prisoners with HIV. This should be repealed or narrowed.

- Articles 69 of the Penal Code of the Kyrgyz Republic does not allow short-term leaves from the correctional facilities in cases of personal emergencies of the same categories of prisoners. It, too, should be repealed or narrowed.

In addition, the current segregation of prisoners based on HIV status is unjustified discrimination and contrary to international, human rights-based recommendations. This policy and practice should be eliminated in Kyrgyzstan, through amendments to the following:

- Penal Code of the Kyrgyz Republic (Articles 17, 48, 68, 69, 73);
- Law “On the order and conditions of holding persons in custody detained on suspicion or charges with a crime” (Article 31);
- “Internal Regulations for correctional facilities of the Ministry of Justice of the Kyrgyz Republic” (paragraph 3); and
- “Regulations of pre-trial detention facilities of the Ministry of Justice of the Kyrgyz Republic” (paragraph 38).

**Discrimination and restriction of rights**

**Recommendation 21: Eliminate discrimination in employment based on HIV status**

Currently, the Constitution has a very broad prohibition on discrimination, and the Law “On HIV/AIDS” prohibits unreasonable refusal to employ, or unreasonable dismissal of, people with HIV or AIDS. This is consistent with international human rights law, and is a welcome feature in Kyrgyz law. Yet the Government of Kyrgyzstan has also adopted a list that restricts people from working in certain trades or occupations based on HIV-positive status, which amounts to discrimination that can rarely be justified. To rectify this inconsistency, and to protect better the rights of people living with HIV, two steps can be taken:

- First, the Government should review the existing list and other official government documents that include HIV on a list of diseases that preclude a person from holding certain positions, and amend them to remove any reference to HIV unless there is a clear, scientifically sound basis establishing that performing such employment cannot be done without posing a significant risk to the health of another person. Such will very rarely be the case — to the point that it would also be entirely possible simply to abolish the list entirely, and if the Ministry of Health needed to develop some specific guidelines or rules to handle the very exceptional cases in a particular kind of work, this could be done; taking a much narrower approach would avoid the overly-broad and discriminatory approach of the current list.

- Second, a legislative amendment to the Law “On HIV/AIDS” should be added that could be worded as follows:

> Discriminating against a person on the basis of his or her actual or perceived HIV infection or AIDS diagnosis [or on the basis of other blood-borne infection] is prohibited, including but not limited to such contexts as employment [or education]. It is unlawful discrimination to require that a person be tested for HIV as a condition of employment [or enrolment in an educational institution], either before or during employment [or enrolment].

**Recommendation 22: Eliminate discrimination against drug-dependent persons in educational and employment settings**

According to the information presented by the national expert group, upon enrolment to certain courses of higher educational institutions, the applicants need to undergo general physical examination, which
includes narcological testing. For example, persons applying for enrolment to military schools must pass a physical examination, including proof of absence of narcological disease.\footnote{\textit{Instruction on physical examination of students and candidates seeking admission to military schools} [\textit{Инструкция о порядке проведения медицинского обследования студентов и кандидатов, ищущих прием в военные \protect\,школы}], No. 199 (\textit{9 September 2000}).} Government guidelines also authorize drug testing of secondary school students.\footnote{\textit{Instruction on the order for the preventive medical examination in educational institutions of the Kyrgyz Republic to detect minors consuming narcotic drugs, psychotropic substances and precursors}, No. 468/662/1 (\textit{15 November 2002}).} However, requiring such testing, and denying enrolment in an educational institution based on a positive drug test (and presumed drug dependence), is unjustifiable discrimination, as well as a violation of privacy rights and security of the person. These instruments should be should be repealed.

Discrimination based on real or perceived drug dependence is also of concern in the employment context. Requiring drug testing \textit{before} employment is unjustified discrimination based on health condition. Requiring testing for drug use \textit{during} employment may only be potentially justifiable in quite limited circumstances, such as limiting testing to positions that are safety-sensitive and then only in cases where there are reasonable grounds to suspect impairment or possibly random drug testing of persons returning to work after receiving treatment for drug dependence.

- It is recommended to begin a consultation process with policy-makers and to study experiences of other countries for models of legislation that limits restrictions on permitted occupations based on drug use only in specific cases defined in the law and based on individual assessments of ability to perform.

- Provisions in the \textit{Law “On narcotic drugs, psychotropic substances and precursors”}, and in the national anti-drug programme, that encourage or permit workplace drug testing in overly broad circumstances should be eliminated.

- Instead, it is recommended that Kyrgyz law (e.g., the \textit{Law “On narcotic drugs, psychotropic substances and precursors”}) be amended to include a provision along the lines of the following:\footnote{\textit{Legislating for Health and Human Rights: Model Law on Drug Use and HIV/AIDS}, Module 7: Stigma and discrimination, pp. 13-15.}

\begin{table}[h]
\centering
\begin{tabular}{|l|l|}
\hline
\textbf{Discrimination based on drug use} & \\
\hline
(1) Absent a reasonable justification given the circumstances of the case, it is prohibited to discriminate against a person, or a relative or associate of the person, on the ground that the person uses or has used drugs, or is perceived to use or have used drugs. & \\
\hline
(2) It is unlawful discrimination to require that a person undergo drug testing as condition of enrolment in an educational institution, either before or during enrolment. & \\
\hline
(3) It is unlawful discrimination to require that a person undergo drug testing as a pre-condition of employment. Making drug testing a condition of continued employment is permitted only in positions, as designated by [suitable government authority], where impairment while at work may pose a significant risk of harm to the individual employee or to others \textit{and} where there are reasonable grounds to suspect that the individual employee may be impaired by drug use. & \\
\hline
\end{tabular}
\end{table}

\textbf{Recommendation 23: Respect and protect family relationships}

Relevant legislation should be amended to clarify that, in cases of concern about child abuse or neglect, drug dependence should not be assumed to be \textit{per se} sufficient grounds to deprive someone of parental rights, but rather a careful analysis of the individual circumstances is required.
TAJIKISTAN: SUMMARY REPORT AND RECOMMENDATIONS

1. BACKGROUND

As a result of its geographical position (bordering Afghanistan, China and the other Central Asian republics of Uzbekistan and Kyrgyzstan) and its unstable social and economic situation, Tajikistan has become a transit corridor for narcotics destined for other countries, meaning that narcotics are also easily accessible and cheap in Tajikistan itself, contributing to their use, including in ways that risk transmission of HIV and other blood-borne diseases. Additional drivers of the HIV epidemic in Tajikistan include high levels of labour migration and low levels of HIV awareness among the population as a whole, with risky activities a consequence, especially among young, such as initiating drug use and engaging in unsafe sex.962

According to UNAIDS, the estimated number of people living with HIV in 2007 was 10,000 (within a range of 5,000 to 23,000).963 As of April 2008, 1153 cases of HIV infection had been officially registered in Tajikistan by health officials, of which 17.5% were among women. Of the total number of HIV infections, according to official data, 57.5% (663) were attributable to infection through injection drug use, while 23.7% (274) were thought to have been acquired through sexual contact.964

One source estimates that some 15,000 people inject drugs in Tajikistan, of which 23.5% have HIV and 43.4% have hepatitis C virus (HCV).965 According to more recently published data, there are estimated 17,000 people in Tajikistan who inject drugs, which represents a prevalence of injecting drug use of 0.45 % (among adults between the ages of 15 and 64).966 The number of officially-registered drug users has risen from 4,200 in 2000 to 8,607 in 2007.967 Older official data indicated that, as of January 2005, there were 9,134 people with drug addiction officially recorded by Tajik authorities; according to government sources, this figure represents only those who had voluntarily applied for narcological assistance. Official estimates suggest that the number of persons who have applied for narcological assistance represents but one-tenth of the actual number of those with drug dependence.968 Since 2001, there has been a sharp increase in the number of persons injecting drugs, now estimated at 49% of the total number of people who use drugs in one way or another (of which 97% are men).969 HIV prevalence among people who inject drugs has been estimated at 14.7 %.970 In 2006, HIV prevalence among injecting drug users in the capital city, Dushanbe, was estimated at 23.5 %.971

According to the information provided by national experts, as of 2008, 118 people in the country were receiving antiretroviral (ARV) treatment. In Tajikistan, there is one national centre on HIV prevention, as well as four provincial, seven district, and three city centres. In 2007, Tajikistan’s prison population included a total of 139 prisoners with diagnosed HIV and 752 prisoners with diagnosed tuberculosis. HIV prevalence in penitentiary institutions was 6.2%, while HCV prevalence was 24.3%.972 According to other estimates, HIV prevalence among prisoners is as high as 8.4%.973 According to official information, of the total number of people living with HIV in Tajikistan, 70% are people who inject drugs and 21% of them are imprisoned.974

962 See the preamble to the "Program on prevention of distribution of narcotic addiction and improvement of narcological assistance in the Republic of Tajikistan for 2005-2010".
964 Statistics provided by national expert group in detailed country report (available in Russian only).
968 See the preamble to the "Program on prevention of distribution of narcotic addiction and improvement of narcological assistance in the Republic of Tajikistan for 2005-2010".
969 Ibid., p. 10.
972 Information provided by the national expert group.
2. NATIONAL PROGRAMMES AND STRATEGIES

Programmes on HIV/AIDS
In 1997, the national government created the National Coordinating Committee (NCC) on prevention and control of HIV/AIDS, tuberculosis and malaria which includes NGOs working with people with drug dependence and people living with HIV (PLHIV).975 In the same year, the government adopted the “National Programme for Prevention and Control of HIV, AIDS and Sexually Transmitted Diseases in the Republic of Tajikistan, 1997-2007”. At the end of this 10-year programme, the national government adopted the new “Programme on Counteracting the HIV/AIDS Epidemic in the Republic of Tajikistan, 2007-2010”, which includes explicit attention to preventing HIV infection among people with drug dependence, sex workers, youth, migrants, and prisoners, as well as efforts to secure the safety of donated blood.976 Among other measures, the programme mentions: establishing needle and syringe programmes (NSPs), including mobile NSPs, to be delivered by NGOs; implementing programmes providing opioid substitution therapy (OST); and training on interventions in cases of overdose. Development of the programme was based on a situation analysis by the Ministry of Health in collaboration with other ministries and departments and non-governmental organizations, with the assistance of the national UNAIDS Theme Group and other international organizations.977 These initiatives reflect measures already contemplated in the Ministry of Health’s own “Strategic Programme on Counteracting the HIV/AIDS Epidemic in Tajikistan for the period 2004-2010”, which programme includes activities aimed at HIV prevention among people who use drugs, sex workers, youth, migrants and prisoners, and also makes explicit reference to implementing NSPs (including mobile programmes conducted by NGOs), opioid substitution therapy and overdose prevention programmes.

Programmes on narcotic drugs
In 1996 and 1999, Tajikistan launched two national programmes to control narcotics; however, some of the activities remained largely declarative, as neither programme contained any provisions for financing and no budget was developed. The decisive and supervising role in the development of the programmes belonged to the Drug Control Agency.978 Aside from law enforcement measures as a strategy for preventing drug use, the drug control programmes were limited to activities aimed at increasing awareness of the general population and youth about drug abuse, and organization of various expert round tables. There were some provisions concerning narcological treatment, such as supplying medical institutions with equipment and expertise, and measures aimed at enhancing the narcological service’s system of registering drug-dependent persons and its interaction with law enforcement bodies. Neither programme mentioned measures aimed at reducing harms associated with the use of illegal drugs.

The national expert group has reported that the national government has recognized the limitations of the law enforcement approach to the prevention and treatment of narcotics addiction, and of the involvement of the Drug Control Agency in medical fields, and has accordingly decided to adjust its national strategy. In April 2005, the Republic of Tajikistan approved the “Programme on Preventing Narcotic Addiction and Improving Narcological Assistance in the Republic of Tajikistan, 2005-2010”.979 As the name suggests, this programme has a medical focus, rather than mixing law enforcement objectives with the treatment of narcotic addiction.

This programme includes activities in areas categorized as “primary prevention” (aimed at preventing the first use of drugs), “secondary prevention” (treatment and rehabilitation programmes to address drug dependence) and “tertiary prevention” (aimed at preventing relapse into drug use following interven-

976 Government of the Republic of Tajikistan, Resolution No.86 (3 March 2007).
977 In addition to the programs described above, the national government has approved both the “National program for prevention and control of hepatitis B in the Republic of Tajikistan, 2000-2007” (Order No. 100, 11 March 2000) and the “National program against tuberculosis in the Republic of Tajikistan, 2003-2010” (Order No. 524, 31 December 2002).
978 According to the Law on narcotic drugs, psychotropic substances and precursors, Law No. 873/874 (10 December 1999), the “Agency is a law enforcement body which co-ordinates and supervises activity of the state bodies on licit turnover of narcotics, psychotropic substances and precursors, trafficking of these substances, the prevention of addiction to narcotics and other toxins, and social rehabilitation for drug addicts and toxic addicts” (para. 5). Thus this document obliges the national drug control agency (which reports directly to the President) to co-ordinate the work of all ministries and departments in these areas.
979 Government Resolution No. 113 (2 April 2005).
The programme’s preamble refers to elements of a harm reduction approach (e.g., the supply of sterile injection equipment), and explicitly notes that a major objective, in addition to preventing drug dependence, is the “prevention of HIV/AIDS transmission through non-sterile tools used during intravenous drug use”. The programme also seeks to review and improve the existing legislation in this area, improve the structure of the state narcological institutions and their relations with the AIDS centres and the non-governmental sector’s health and social services. Priorities include comprehensive programmes of harm reduction.

According to the national expert group, this programme has not been fully implemented on time. However, in 2006 the Ministry of Health approved an order “On the improvement of narcological assistance in the Republic of Tajikistan”, which assigns new functions to the narcological service, including the realization of narcological assistance based on harm reduction methods, including the implementation of opioid substitution treatment. According to the national expert group, introducing the approved standards of narcological assistance will require both a substantial increase in the annual budget of the narcological service and significant investments to reorganize it and equip it with materials and personnel. The programme does not define the sources and size of financing, simply mentioning “state funding” and “grants of international organizations”.

To promote the success of these programmes, the national expert group has recommended: creating and strengthening monitoring mechanisms to track performance and the efficiency of measures adopted; accurately developing the budget to support these programmes; and clearly identifying those responsible for implementation. The national expert group has also recommended the active involvement of civil society in the implementation and monitoring of the programmes.

3. ADMINISTRATIVE AND CRIMINAL LAW PROVISIONS ON NARCOTIC DRUGS

Prohibition on drug use but without penalty
Consumption of narcotics per se is neither a crime nor an administrative offence under Tajik law. Article 15 of the 1999 Law on narcotics, psychotropic substances and precursors states that the consumption of narcotics and psychotropic substances without a prescription from a medical doctor is prohibited. However, there is no penalty prescribed, and neither the Administrative Code nor the Criminal Code addresses this issue.

In 2004 the Criminal Code of Tajikistan was amended to significantly increase in the minimum quantity of substance leading to criminal charges, thus placing Tajikistan among countries with more progressive drug policies in the post-Soviet region.

TABLE: Reforms to Tajikistan’s criminal laws on drugs

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Quantity</td>
<td>Penalty</td>
</tr>
<tr>
<td>Heroin</td>
<td>0.015-0.15 g</td>
<td>Prison sentence of 5-10 years with confiscation of property</td>
</tr>
<tr>
<td>Opium</td>
<td>0.15-1 g</td>
<td>5-10 g</td>
</tr>
<tr>
<td>Hashish</td>
<td>0.1-10 g</td>
<td></td>
</tr>
</tbody>
</table>

Administrative offences
The Code of the Republic of Tajikistan on Administrative Responsibility (“Administrative Code”) makes it an administrative offence to illegally manufacture, produce, process, acquire, possess, transport or transfer narcotics without an intention to sell. The penalty for such administrative offences is a fine ranging from 12 to 30 times the official minimum wage. Administrative liability applies only when the quantity of narcotic or psychotropic substance falls below the threshold of the “small” amount that triggers criminal liability (see below). The quantity of a narcotic or psychotropic substance required to trigger criminal liability (e.g. 0.5g in the case of heroin) is higher than comparable thresholds set in the law of neighbouring republics, making Tajik law the most liberal, in this regard, of the countries of the former Soviet Union.

Criminal offences
Tajikistan’s Criminal Code establishes criminal liability for the following acts with the possible penalties (including minimum penalties in some cases) as indicated.

982 Code of the Republic of Tajikistan on Administrative Responsibility, Article 42(1).
983 See appendix for the table on quantities of substances.
• illicit distribution of narcotic drugs and psychotropic substances, *without an intention to sell*, in
  - “small” quantities (a fine or up to two years’ imprisonment);
  - in “minor” quantities (two-five years’ imprisonment);
  - as a repeat offence, by an organized group, in prisons, using an official capacity, or in large quantities (five-eight years’ imprisonment with or without confiscation of property); or
  - in “extra large quantities” (eight-12 years’ imprisonment with or without confiscation of property).\(^985\)
• manufacturing, producing, processing, acquiring, possessing, transporting or transferring narcotics and psychotropic substances, *with an intention to sell*,
  - in “small” quantities (up to five years’ imprisonment);
  - in “minor” quantities (five-eight years’ imprisonment);
  - as a repeat offence, in schools, or by an organized group (8-12 years’ imprisonment, with or without confiscation of property); or
  - in prisons or in “large quantities” (12-20 years’ imprisonment with confiscation of property).\(^986\)
• theft of narcotic drugs and substances (three-15 years’ imprisonment);\(^987\)
• illicit distribution of precursors (a fine or from two to eight years’ imprisonment, depending on quantity)\(^988\)
• “involving” other persons in the consumption of narcotics or psychotropic substances (imprisonment for up to five years), or involvement of another person with aggravating circumstances (e.g., in relation to a minor, involving two or more persons, using violence, as a repeat offence, in prisons, or by an organized group) (three to five years’ imprisonment);\(^989\)
• illicit cultivation of prohibited plants containing narcotic substances (a fine or up to 12 years’ imprisonment),\(^990\) and
• organizing or maintaining “sites” for the consumption of narcotics or psychotropic substances (three to ten years’ imprisonment).\(^991\)

As noted above, the possession of quite small amounts of a prohibited drug without an intention to sell — *de facto*, possession for personal use only — amounts to an administrative offence under the *Administrative Code*. Once the amount reaches a certain threshold, it may trigger criminal liability. While Tajikistan’s *Criminal Code* does not explicitly recognize the concept of possession of narcotic substances “for personal consumption”, it does provide for lesser penalties in the case of first offences involving small quantities of prohibited drugs where the activity is done “without intention to sell”: possession or other activities involving “small” amounts of narcotics (the amounts are defined in schedules adopted by a Government resolution), and without the intention to sell, attracts a fine as the minimum penalty for a first offence.\(^992\) However, subsequent offences of this sort are punished quite harshly: subsequent convictions can attract a mandatory minimum sentence of imprisonment from five to eight years (even for small amounts of drugs). In addition, a court may order the confiscation of property in the event the offence is committed with aggravating circumstances — indeed this penalty is applied as a general rule in the presence of aggravating circumstances, such as a repeat offence, an offence committed by an organized group or someone in an official capacity, an offence committed in a prison, or an offence involving large quantities of the prohibited substance.\(^993\) Being under the influence of drugs at the time of an offence is not an aggravating circumstance, which is a welcome feature in contrast with the laws of several other countries in the region.

**Needle and syringe programmes: legal issues**

Needle and syringe programmes (NSPs) operate in Tajikistan, although the country has not yet developed or approved official procedures for such programmes. Tajik law does not limit the sale of needles and syringes in pharmacies, nor is the possession of drug paraphernalia a criminal offence. However, the

\(^{985}\) *Criminal Code*, Article 201.
\(^{986}\) *Criminal Code*, Article 200.
\(^{987}\) *Criminal Code*, Articles 202.
\(^{988}\) *Criminal Code*, Articles 202(1).
\(^{989}\) *Criminal Code*, Articles 203. The term “involvement” is not defined.
\(^{990}\) *Criminal Code*, Articles 204.
\(^{991}\) *Criminal Code*, Article 205.
\(^{992}\) *Criminal Code*, Article 201.
\(^{993}\) *Criminal Code*, Articles 200-204.
national expert group notes that, in theory, NGOs that implement NSPs could potentially be liable under provision on “involvement” in the consumption of narcotics (Criminal Code, Article 203) or organizing a site for drug consumption (Criminal Code, Article 205). The national expert group recommends that the law be clarified to exclude the activities of personnel of NSPs — which activities are conducted with a view to preventing HIV and other blood-borne infections among people who use drugs — from the scope of potential legal liability.

Compulsory drug testing, including by law enforcement

Tajikistan’s Law “On narcotic drugs, psychotropic substances and precursors” has an extremely wide provision aimed at detecting those who consume narcotic substances: “if there are sufficient grounds [достаточные основания] to believe that a person has consumed illegal narcotics or psychotropic substances, s/he shall be subject to physical examination in narcological institutions of the Ministry of Health.”

The Law “On narcological assistance” further expands that legislation and limits the rights of persons, beyond the criminal law context: “Where there are grounds to believe that a person suffers from drug dependence, alcoholism, is under the influence of alcohol or narcotics, or has used a narcotic or psychotropic substance without a prescription from a medical doctor, the person may be referred for physical examination.”

Law enforcement bodies, following the procedure established by law, take persons suspected of committing crimes connected with narcotics or psychotropic substances for such examination, with a view to establishing the use of narcotics or psychotropic substances.

However, such wide provisions on compulsory drug testing, vesting such extensive powers in law enforcement bodies, represent not only an inefficient use of limited resources but also an unjustified intrusion on human rights. For example, subjecting someone who has not committed any offence to involuntary drug testing violates the rights to liberty, security of the person and privacy, as well as the right to be free from non-consensual medical intervention; if test results are also used against the person in any sort of prosecution, it would also violate the right against self-incrimination. The only possible bases on which it might be justifiable for the state to infringe such human rights would be to intervene to prevent a serious risk of harm to oneself or to others; mere use of alcohol or drugs does not, by itself, establish this.

Groups at higher risk of HIV: criminal and administrative law issues

Sex work:

According to the Administrative Code of Tajikistan, prostitution is an administrative offence and leads to a warning or fine in the amount of ½ of one monthly minimal wage. Repeated offence committed within the same year leads to a higher fine of 2 minimal monthly wage.

Article 238 of the Criminal Code criminalises “involvement” in prostitution using force, coercion or threats. Article 239 provides for criminal liability for organising and maintenance of brothels or pimping, which is punishable by fine, or imprisonment for up to five years.

The International Guidelines on HIV/AIDS and Human Rights recommend that “with regard to adult sex work that involves no victimization, criminal law should be reviewed with the aim of decriminalising and legally regulating occupational health and safety conditions to protect sex workers and their clients, including support for safe sex during sex work.” Criminalizing sex work and sex workers contributes to their further stigmatization and marginalization, putting them at greater risk of human rights abuses and exacerbating vulnerability to HIV. It is recommended to repeal Article 174.1 of the Administrative Code of Tajikistan. Articles 238-239 of the Criminal Code are sufficient for punishing criminal behaviour in relation to sex work.

995 Law “On narcological assistance”, No.67 (8 December 2003), Article 18.
996 International Covenant on Civil and Political Rights, 999 U.N.T.S. 171 (1966), Articles 7, 9, 14, 17.
997 Administrative Code, Article 174.1.
998 Criminal Code, Articles 238-239.
999 International Guidelines on HIV/AIDS and Human Rights, Guideline 4, para. 21(c).
HIV and STI exposure and transmission

Article 125 of the Criminal Code of Tajikistan provides liability for:

- Knowingly exposing someone to HIV - is punishable with limitation of freedom for up to three years or imprisonment for up to two years.
- HIV transmission by person who knew of his/her infection – is punishable by imprisonment from two to five years.
- HIV transmission by someone who knew of his/her HIV infection committed in relation to two or more people or a minor – is punishable by imprisonment from five to ten years.

According to Article 126 of the Criminal Code, "transmission of venereal disease, by someone who knew of his/her disease – is punishable by fine, correctional works from one to two years, or arrest for up to six month. The same offence, committed in relation to two or more people, or a minor – is punishable by fine, imprisonment for up to two years.

Having a specific criminal offence singling out HIV exposure and negligent HIV and STI transmission, runs contrary to internationally recommended policy, in part because it stigmatizes people living with HIV, and people vulnerable to it, and creates a further disincentive for HIV and STI testing and an additional barrier to access to health services. The International Guidelines on HIV/AIDS and Human Rights recommend against such an approach: criminal legislation should not include specific offences regarding HIV transmission or exposure, and the scope of applying criminal law should be limited to those cases where someone acts with malicious intent to transmit HIV and does in fact transmit the virus.  

4. HEALTH SYSTEM AND SERVICES

All medical services provided by the state are free of charge. Access to health services for persons with HIV or AIDS, and for those with drug dependence, is guaranteed by the state. Foreigners, including migrants and refugees, get access to medical services for the treatment of HIV/AIDS and drug dependence on an equal basis with Tajik citizens.

4A. DRUG DEPENDENCE PREVENTION AND TREATMENT

The Ministry of Health reports that the principal method of treatment for drug dependence in Tajikistan consists of short-term courses of detoxification (mainly assisted by medication). The actual success rate of the current medical treatment of heroin drug addiction does not exceed 6-8% a year (success means complete abstinence (drug free status) confirmed by periodic drug tests and medical examination performed over 12 months after completing the formal treatment course). Official documents, in particular the “Programme on preventing narcotic addiction and improving the narcological assistance in the Republic of Tajikistan, 2005-2010”, have highlighted problems in the narcological assistance system.

To solve these problems, in 2006, the Ministry of Health issued an order that, among other things, sets out standards for monitoring the narcological situation in Tajikistan, establishes a series of “trust points” (points of narcological assistance in the system of HIV prevention among injection drug users), and contains a provision on narcological rehabilitation centres. The national monitoring aims to assist in planning efforts to prevent drug dependence and in evaluating the adequacy and efficiency of measures being pursued.

"Trust points" are established with the objectives of reducing HIV infection among people who use drugs and ensuring their easy access to medical aid in all treatment institutions, as well as preventing drug dependence among the population. Trust points are located within the AIDS centres, narcological clinics, and other medical institutions. HIV prevention among people who use drugs can be done by the non-governmental organizations. Trust points have the following functions:

- distributing sterile syringes, disinfectants, condoms, and information materials, as well as collecting and disposing of used syringes;
- providing information on HIV and other sexually transmitted infections (STI);
- providing social assistance, such as: help with social, legal, and housing questions; material aid; vocational training and help finding employment;
- providing counselling on HIV/AIDS, medical and social rehabilitation from drug dependence, consultations with other medical doctors and referrals for specialized medical assistance;
- providing testing for HIV, hepatitis, STIs, as well as psychological testing; and
- providing substitution therapy.

The Law on narcological assistance is the principal piece of legislation governing treatment of drug dependence in Tajikistan. The very fact that such a law exists is welcome — this is in contrast with several other countries in the region, where treatment of drug dependence is governed by a few articles in the national law on narcotics. At least in theory, it separates drug dependence treatment from the scope of activities of criminal law enforcement, placing it instead in the health sphere. Regulating activity connected with lawful drug distribution and counteracting illegal trafficking of narcotics remains the jurisdiction of law enforcement bodies, whereas treating drug dependence is a health activity that better fits within the jurisdiction of health authorities. (However, as noted further below, the degree to which the law requires narcological treatment providers to give information about patients to law enforcement bodies remains some cause for concern.)

1002 “Program on preventing narcotic addiction and improving narcological assistance in the Republic of Tajikistan, 2005-2010”, p 11.
Under the Law on narcological assistance, people who have voluntarily sought drug dependence treatment have the right to:

- free narcological assistance provided by the Ministry of Health;
- “anonymity” of treatment;\(^{1004}\)
- sick leave (from employment) for the duration of a stay at a narcological centre, thereby preserving entitled to one’s employment; and
- keep one’s housing and employment during hospitalization at a narcological centre.\(^{1005}\)

The law also provides for psychological, medical and social rehabilitation in state and non-state rehabilitation centres for persons with drug or other chemical dependencies, after a course of treatment in a narcological institution.\(^{1006}\)

The law recognizes a number of rights of persons undergoing examination or treatment in a narcological centre, including:

- the right to maintain private correspondence without censorship;
- the right to receive packages and parcels;
- the right to receive visitors during set times; and
- the right to have and obtain personal articles.\(^{1007}\)

These rights may be limited by the attending physician or chief physician of the institution only if absolutely necessary in the interests of health or safety of the patient or other persons.\(^{1008}\) The list of rights in the legislation does not include the right to participate in making decisions about one’s own health, including such basic rights as the right to appeal against a decision by the facility’s administration or the right to refuse or stop treatment.

**Registration of people who use drugs**

Registration of people who use or are dependent on drugs is carried out in accordance with an order of the Ministry of Health\(^ {1009}\) and the Law on narcological assistance, which states that “decisions regarding the registration/deregistration of people with drug dependence or people who use drugs for non-medical purposes, are made by a commission of narcologists and psychiatrists.”\(^ {1010}\) One area of concern is the provision on cooperation of narcological institutions with the law enforcement bodies.\(^ {1011}\) While the Law on narcological assistance specifically imposes a duty to preserve medical confidentiality with regard to narcological dependence, there are numerous, very broad exceptions: data related to a person’s narcological dependence is reported, following receipt of a written inquiry, to narcological institutions, superior public health bodies, the public prosecutor, and judicial and investigative bodies.\(^ {1012}\) For treatment centres to provide such information to law enforcement authorities creates a potential disincentive to seeking drug dependence treatment, which hinders effective prevention and treatment of HIV among people who use drugs; the legislative provisions facilitating or requiring such practice should be repealed or significantly narrowed.

**Compulsory drug dependence treatment**

Under the Law on narcological assistance, the law states that a person may be involuntarily urgently hospitalized in a narcological centre in circumstances where she or he has grave psychological and somatic...
disorder arising out of the use of psychoactive substances, such that she or he: (i) poses a direct danger to himself or herself or to other people; (ii) is unable to satisfy independently his or her own vital needs; or (iii) will, if untreated, suffer deterioration of mental condition causing serious harm to his or her health.\textsuperscript{1013}

In addition, under the \textit{Law on compulsory treatment of people with alcoholism and drug dependence},\textsuperscript{1014} all persons with drug dependence or alcoholism are declared to have a legal duty to seek and undergo treatment in institutions of the public health services. Those who evade treatment may be ordered by a court into specialized institutions for compulsory treatment. According to this statute, persons with drug dependence are supposed to be placed into special facilities for compulsory treatment which combine medical therapy and labour and are operated by the Ministry of Interior.\textsuperscript{1015} However, according to the national expert group, these specialized facilities do not exist because of lack of funding and this law on compulsory treatment is not enforced (outside of prisons) because of lack of facilities to conduct compulsory treatment.

Enforcement of compulsory treatment is, however, the practice in the case of those convicted of a criminal offence. As noted above, upon being charged with a criminal offence, a person suspected of drug use will be required to undergo narcological examination. In the event that addiction is established, the court will order compulsory drug dependence treatment while in prison. The \textit{Criminal Code} provides that compulsory treatment shall be imposed as part of the penal sentence, and that this shall be in addition to imprisonment, rather than as an alternative to imprisonment.\textsuperscript{1016} It should be noted that, in this respect, Tajik law does not take full advantage of the flexibility offered by UN treaties on drug control, which explicitly allow States Parties to those treaties to include, in their domestic legislation, \textit{alternatives} to conviction and incarceration for drug offences, including measures for treatment.\textsuperscript{1017}

\textbf{Opioid substitution treatment}

Opioid substitution treatment (OST) is a well-studied, effective method of managing and treating opioid addiction used widely in many jurisdictions, and is recognized as a key element of HIV prevention among people who inject drugs.\textsuperscript{1018} International drug control treaties ratified by Tajikistan do not prevent the use of medications such as methadone and buprenorphine as OST,\textsuperscript{1019} and they are recognized by the World Health Organization as “essential medicines”.\textsuperscript{1020} Tajik law does not prevent the introduction of OST, but rather explicitly allows it.\textsuperscript{1021}

However, the implementation of OST is lagging in Tajikistan. Against a backdrop of widespread addiction to opioids and a growing HIV epidemic linked to injection drug use, there is a need for quick action on this front, both to protect public health and to discharge Tajikistan’s international human rights obligations, including the obligation to take positive measures to realize the highest attainable standard of health.\textsuperscript{1022} Both the Ministry of Health’s 2006 Order “On improving narcological assistance”\textsuperscript{1023} and the “Programme on counteracting the HIV/AIDS epidemic in the Republic of Tajikistan, 2007-2010”\textsuperscript{1024} mention substitution therapy. In 2008, welcome steps were taken toward introducing OST in two pilot programmes.\textsuperscript{1025} It will be critical to ensure that such programmes are established and scaled-up successfully, and do not remain perpetually in the pilot phase, if their health benefits, including assisting with HIV prevention among people who inject drugs, are to be maximized.

\begin{thebibliography}{9}
\bibitem{1013} \textit{Law on narcological assistance}, Article 9.
\bibitem{1014} \textit{Law on compulsory treatment of people with alcoholism and drug dependence} (12 April 1991).
\bibitem{1015} \textit{Ibid}.
\bibitem{1016} \textit{Criminal Code}, Articles 96-101.
\bibitem{1017} \textit{Single Convention on Narcotic Drugs}, 1961, UN, 520 UNTS 331, as amended by the 1972 Protocol, Article 36(2); \textit{Convention on Psychotropic Substances}, 1971, UN, 1019 UNTS 175, Article 22; \textit{Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances}, 1988, Article 3(4).
\bibitem{1020} \textit{WHO}, \textit{WHO Model List of Essential Medicines}, regularly updated, online: http://www.who.int/medicines/publications/essentialmedicines.
\bibitem{1021} Article 9 of the \textit{Law on narcological assistance} mentions “alternative substitution therapy for those sick with narcotic addiction.”
\bibitem{1022} \textit{International Covenant on Economic, Social and Cultural Rights}, UN General Assembly, 993 UNTS 3 (1966), Articles 2 and 12.
\bibitem{1023} Ministry of Health, \textit{Order No.485}.
\bibitem{1024} “Program on Countering the HIV/AIDS Epidemic in the Republic of Tajikistan, 2007-2010”, Order No.86 (3 March 2007).
\bibitem{1025} Interview with Soulkhiddin Nidoev, Director of National Drug Monitoring and Prevention Centre of Tajikistan, Dushanbe, 11 October 2008.
\end{thebibliography}
**Overdose prevention**

Naloxone, an opioid antagonist medication used to counter the effects of opioid overdose (including suppression of the central nervous and respiratory systems), is listed by the WHO as an essential medication for treating poisonings.\(^{1026}\) Naloxone has been registered in Tajikistan and is used by medical institutions to help in cases of overdose.\(^{1027}\) However, it is included in the list of controlled substances, and is not legally handed out to people who use drugs, meaning that peer interventions (i.e., one drug user assisting another in the event of overdose) are not possible.

### 4B. HIV PREVENTION AND TREATMENT

Tajikistan’s first *Law on prevention of the AIDS disease* was adopted in 1993. It was revised in 2005 and adopted as the new *Law on counteracting HIV/AIDS*, which was again amended at the end of 2008.\(^ {1028}\) The amended law contains a number of important provisions. In particular, the law:

- guarantees to “vulnerable groups” specific information and services aimed at changing risk behaviour;\(^ {1029}\)
- proclaims that HIV prevention is a government priority and that government action should be based on the principles of human rights;
- establishes the availability of anonymous and voluntary testing (although Tajik law also has numerous exceptions to this principle, noted below);\(^ {1030}\)
- includes HIV test results within the category of confidential information protected by law;\(^ {1031}\) and clarifies that state organizations are allowed to share health information without a person’s consent only following a court order or the request of investigative law enforcement bodies;\(^ {1032}\)
- establishes that various kinds of qualified medical (including psychological) and social assistance is available free of charge to persons with HIV/AIDS;\(^ {1033}\)
- prohibits discrimination based on HIV-positive status in all areas, including access to treatment, in labour and in education, and prohibits the restriction of housing and other rights and legitimate interests of people with HIV and members of their families;\(^ {1034}\)
- establishes controls for the safety of medical preparations, biological fluids and tissues used for medical and scientific purposes;\(^ {1035}\)
- guarantees provision of HIV-related information and educational activities in penitentiaries;\(^ {1036}\)
- guarantees rights of prisoners and detainees to adequate health care services, counselling and referral to other health care services;
- stipulates the right of prisoners and detainees to confidential HIV testing and counseling with informed consent of the person;\(^ {1037}\) and
- prohibits discrimination of prisoners on the grounds of their HIV status.

One of the other welcome developments of the 2008 amendments to the HIV law is the abolition of deportation of foreigners testing HIV-positive (see below); however, the law still allows for the compulsory HIV testing of foreigners.

**Addressing HIV among groups at high risk**

The *Law on counteracting HIV/AIDS* specifically contemplates the need for efforts to address groups vul-

---


\(^{1027}\) Use of naloxone is governed by the Ministry of Health’s order “On improving narcological assistance in the Republic of Tajikistan”, Order No. 485 (7 August 2006).


\(^{1029}\) Ibid., Article 6.

\(^{1030}\) Ibid., Articles 7-8.

\(^{1031}\) Ibid., Article 11.

\(^{1032}\) Ibid., Article 12.

\(^{1033}\) Ibid., Article 14.

\(^{1034}\) Ibid., Articles 8, 11, 12 and 13.

\(^{1035}\) Ibid., Article 4.

\(^{1036}\) Ibid.

\(^{1037}\) Ibid., Article 14-1.
ntersectoral cooperation in counteracting HIV/AIDS, the law provides that official bodies of the public health services, together with the institutions addressing drug trafficking and public safety, in cooperation with public organizations, should develop and implement programmes for preventing HIV infection among injection drug users and other vulnerable groups. NGOs operate drop-in centres for people who use drugs in the cities of Dushanbe, Khujand and Khorog. With grants from the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM), 12 centres for sex workers, including some run by NGOs, were opened in the country, offering pre-test HIV counselling, condoms, HIV information and other and educational materials.

**Compulsory or mandatory testing for HIV**

HIV testing may be done in state public health services and private institutions that have received a proper license. According to the current law on HIV, donors of blood, organs, or tissues are subject to mandatory confidential HIV tests as a condition of donating. Some other categories of people, based on "epidemiological indications", are subject to compulsory HIV testing. However, the potentially negative impact of this provision is mitigated by the amendments of 2008 to the national law on HIV: as amended, the law now states that "epidemiological surveillance" is conducted with regard to the protection and priority of human rights and the confidentiality of test results.

In 2008, the Government of Tajikistan issued a resolution adopting a protocol on HIV testing, clarifying procedures of HIV testing and groups of people subject to mandatory and compulsory testing. The protocol lays down a detailed procedure for obtaining informed consent to HIV testing, the right to refuse testing at any stage, and the lists of people and professions required to undergo regular check-ups and obligatory testing. The protocol contains progressive elements such as providing for free, anonymous HIV testing and stating that pregnant women are tested voluntarily. Furthermore, all public and private bodies are prohibited from requiring a person to provide a medical certificate as to HIV status (except in circumstances stipulated in the protocol).

However, serious concerns remain with the scope of compulsory HIV testing under current Tajik law. Under the protocol adopted in 2008, persons with symptoms of HIV or AIDS, or symptoms of diseases associated with HIV/AIDS may be tested without consent. The appendix to the protocol specifies groups of people who have to undergo HIV testing at employment and during regular check-ups:

- patients with clinical indications associated with HIV/AIDS (fever, diarrhea, loss of body mass, etc);
- patients with suspicion or diagnosis of certain diseases (e.g., Kaposi's sarcoma, tuberculosis, hepatitis B and C, etc.);
- patients who regularly receive blood transfusions;
- patients who have received donated blood or organs;
- children born to mothers living with HIV.

Additionally, involuntary HIV testing is conducted for certain people on the basis of "epidemiological indications", and as a pre-condition of employment and at regular check-ups. Appendix 3 to the protocol specifies groups of people who have to undergo HIV testing at employment and during regular check-ups:

---

1038 Law on counteracting HIV/AIDS, Article 23.
1039 Ibid., Article 9.
1040 Ibid, Article 4.
1041 Government of Tajikistan, "On Procedure of testing in order to identify persons infected with HIV, their registration, medical assistance to and surveillance of people living with HIV, and the list of people obliged to undergo mandatory confidential HIV testing on epidemiological indications" [ОБ утверждении Порядка медицинского освидетельствования с целью выявления заражения вирусом иммунодефицита человека, учета медицинского обследования ВИЧ-инфицированных и профилактического наблюдения за ними и Списка лиц, подлежащих обязательному конфиденциальном медицинскому освидетельствованию на ВИЧ-инфекцию по эпидемиологическим показаниям], Resolution No. 171 (1 April 2008).
1042 Ibid., para. 7.
1043 Ibid., para 30.
1044 Ibid., para. 8.
1045 Ibid., Appendix 5, List of people to be mandatorily tested for HIV [Список лиц, подлежащих обязательному медицинскому обследованию на выявление заражения вирусом иммунодефицита человека].
1046 Ibid., para. 9.
- medical doctors, nurses who work at AIDS centres, other healthcare facilities who work with people living with HIV, and staff who carry out medical exam ordered by courts;
- health care staff of medical labs which carry out HIV testing;
- health care staff who deal with blood, such as surgeons, dentists, kidney specialists and those who assist with childbirth; and
- tattoo providers.\textsuperscript{1047}

In addition, if employees of certain professions and positions are found to be HIV-positive, they must be transferred to a different occupation or work. If these workers refuse to undergo HIV testing, they are dismissed from work. Appendix 4 to the protocol specifies these professions:

- surgeons, those who assist with childbirth, specialists performing blood transfusions, and other specialists who work with blood; and
- health care staff working in infectious diseases settings where there is risk of developing HIV-associated illnesses (e.g., tuberculosis).\textsuperscript{1048}

Following legislative amendments in 2008, any mandatory medical testing is carried out confidentially.\textsuperscript{1049}

People living with HIV and AIDS are subject to registration and surveillance (i.e., medical follow-up).\textsuperscript{1050}

Surveillance is carried out by AIDS centre and local health care facilities at least once every six months.\textsuperscript{1051}

As mentioned before, the law on HIV now states that "epidemiological surveillance" is carried out with regard to the protection and priority of human rights and the confidentiality of test results.\textsuperscript{1052}

Foreign citizens entering Tajikistan for work, study, permanent residence or other purposes for more than three months are required to be tested for HIV within ten days from the date of arrival (unless arriving with a certificate of HIV-negative status). Until 2008 foreign citizens or stateless persons who tested HIV-positive were subject to deportation. In 2008, amendments to the national HIV law removed the deportation provision, although mandatory testing of foreigners remains in the law.\textsuperscript{1053}

\textbf{Compulsory treatment of HIV and other diseases and obligation to follow medical instructions}

The \textit{Law on public health care} establishes a general duty on everybody, without exception, to observe medical prescriptions issued by physicians.\textsuperscript{1054} Furthermore, to prevent infectious diseases, people are obliged to receive immunization and medical examinations as determined by the bodies and institutions of the public health services. Failing or refusing to follow instructions or prescriptions of the attending physician constitutes evading treatment and can result in legal liability of the patient (or, in the case of minors, legal liability on the part of his or her parents or legal guardian).

The \textit{Law on public health care} also addresses a number of specific health conditions of concern. People with tuberculosis, leprosy, AIDS, "venereal diseases" and other dangerous diseases (which are not further specified), are obliged to undergo examination and treatment upon request by medical institutions. Those who evade examination and treatment are subject to a compulsory enforcement of testing and treatment.\textsuperscript{1055} In the case where a person evades "voluntary" treatment, the law provides for compulsory treatment.\textsuperscript{1056} However, such provisions contradict other provisions of the \textit{Law on public health care}: with the exception of pregnant women and minors, people have the right to refuse examination and treatment (in writing) at any stage for the diseases.\textsuperscript{1057} (Persons who do not attend for examination or treatment, or...
those who transmit venereal diseases or HIV, may be held criminally liable.¹⁰⁵⁸)

Despite these restrictive provisions, there is a welcome difference between Tajik law and that of neighbouring countries in that, apart from the one provision of the Law on public health care noted just above, there is no separate definition and list of “socially dangerous diseases” in the legislation of Tajikistan. Lists of “socially dangerous diseases”, which habitually include HIV and sometimes drug dependence, exist in several other countries in the region, and are used as a basis for (further) unjustifiable restrictions on the rights of people with the listed conditions.

**Patients’ rights, including confidentiality**

The rights of medical patients in Tajikistan are stipulated by the Law on public health care, which states that a patient has the rights to a respectful and humane treatment from medical and other service personnel, to choose his or her doctor, and to the presence of a lawyer or other lawful representative for the protection of his or her rights.¹⁰⁵⁹ However, this list does not address such questions as the right to participate in choosing one’s treatment or the protection of confidentiality of personal health information.

Separately, the Law on counteracting HIV/AIDS also establishes the rights of patients with HIV and AIDS. In addition to prohibiting medical institutions or emergency services from denying services to persons with HIV or AIDS, the law recognizes:

- the right to receive various kinds of medical aid (including specialized care) and medications;
- the right to confidentiality of health information, as long as a patient’s condition and his or her life and work do not create a threat of infecting other persons with HIV;
- the right to compensation for damages suffered as a result of disclosure of information on HIV infection;
- the right to protection against discrimination, including in access to treatment; and
- the right to patients’ active participation in determining goals of the treatment, including duration and methods, and termination of treatment.¹⁰⁶⁰

Disclosure of “medical secrets” is a criminal offence in Tajikistan, punishable by a fine amounting to 200-500 times the official minimum wage and/or a prohibition on occupying certain posts or engaging in certain activities for up to two years.¹⁰⁶¹ The same Criminal Code article provides for an even more severe penalty for breaching the confidentiality of a patient living with HIV, which may be punishable by imprisonment for up to two years, with a prohibition on occupying certain posts or engaging in certain activities for the same term. If violating patient confidentiality has led to grave consequences, the penalty may be increased to imprisonment for a term of two to five years, again accompanied by a prohibition on occupying certain posts or engaging in certain activities.¹⁰⁶²

The Law on counteracting HIV/AIDS also explicitly establishes that a person’s HIV status or AIDS diagnosis constitutes a professional secret, the confidentiality of which is protected by the law.¹⁰⁶³ Sharing of information about patients’ health without their consent is allowed only following a court order or request by the investigatory bodies of the law enforcement. Each AIDS centre maintains a database of people with HIV with which it has contact. The composite database is stored in the national AIDS centre. Access to this main database is granted only to the head of the centre. No other organizations or individuals have lawful access to this database.

---

¹⁰⁵⁸ Article 125 of the Criminal Code states that knowingly putting someone in danger of HIV infection is punished by a limitation of freedom for up to three years, or imprisonment for up to two years. Transmission of HIV by a person who knew of his/her HIV status is punished by imprisonment from two to five years. Article 126 of the Criminal Code provides for a fine or community labour for one to two years, or detention for up to six months for transmitting STIs.

¹⁰⁵⁹ Law on public health care, Article 31.


¹⁰⁶¹ Criminal Code, Article 145.

¹⁰⁶² Criminal Code, Article 145(2), amended by Law No. 35 (17 May 2004).

¹⁰⁶³ Law on counteracting HIV/AIDS, Article 11.
5. PRISONS

Tajikistan’s correctional system

The correctional system falls under the purview of the Ministry of Justice. As of 2007, it consisted of 19 institutions: one prison, five investigative custody units, three “maximum security” colonies (for men), two “medium security” colonies (for men), one “minimum security” colony (for men), one institution for women (all levels of security), three settlement-type colonies (which are based on a less strict security level than other colonies), a hospital, and an institution for former law enforcement staff (all levels of security).

According to the national expert group, as of 2007, Tajikistan’s correctional facilities contained a total of 2,328 persons serving punishments for drug or drug-related offences, representing roughly one-third of all those serving a term in correctional institutions. Depending on the gravity of an offence, offenders are generally sentenced to “maximum security” correctional facilities or “medium security” facilities; a minority is imprisoned in “minimum security” facilities or in special institutions for personnel of law enforcement bodies.\(^\text{1064}\) In the case of less serious offences, a convicted person may be sentenced to a settlement-type colony or receive a conditional sentence that is served in the community rather than in a correctional institution.\(^\text{1065}\) The national expert group notes that the correctional system does not maintain a tally of persons released on parole or receiving alternative punishments (i.e., not incarceration) for drug-related crimes.

The Criminal Code provides for exemption from punishment in some cases of disease.\(^\text{1066}\) According to a joint order of the Ministries of Justice and Health, people with HIV infection in the stage of secondary diseases, with malignant neoplasms or disorders of the central nervous system, are exempted from further punishment.\(^\text{1067}\) There are also cases when, after serving part of a sentence a person could be granted parole.\(^\text{1068}\) Enforcement of a sentence may also be postponed if the person is undergoing psychiatric treatment.

HIV and risk behaviour in Tajikistan’s prisons

As elsewhere, prisoners in Tajikistan are one of the groups most vulnerable to HIV infection. There is some data suggesting HIV risk behaviour likely occur in prisons in Tajikistan. For example, according to UNODC, more than one-third of prisoners had previously injected drugs.\(^\text{1070}\) The following table shows, for recent years, the number of prisoners known to be living with HIV or tuberculosis in correctional institutions in Tajikistan:

<table>
<thead>
<tr>
<th>Health condition/year</th>
<th>2003</th>
<th>2004</th>
<th>2005</th>
<th>2006</th>
<th>2007</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of prisoners with HIV infection</td>
<td>52</td>
<td>92</td>
<td>115</td>
<td>128</td>
<td>129</td>
</tr>
<tr>
<td>Number of prisoners with tuberculosis</td>
<td>1800</td>
<td>1760</td>
<td>919</td>
<td>929</td>
<td>752</td>
</tr>
</tbody>
</table>

HIV prevention measures in prisons

The Ministry of Health’s strategic plan on HIV/AIDS, adopted in 2004 and running until 2010, specifically recognizes the need for “prevention of HIV infection among prisoners.”\(^\text{1071}\) According to the Ministry’s

---

\(^{1064}\) According to the national expert group of the Republic of Tajikistan, the breakdown of this total number of people in prison for drug-related offences in 2007 was as follows: 1528 persons in maximum security facilities, 778 persons in medium security facilities, 22 persons in minimum security facilities and 103 in special institutions for law enforcement personnel.


\(^{1067}\) Criminal Code, Article 79.


\(^{1069}\) Central Asia: Kyrgyz Republic, Tajikistan and Uzbekistan: Regional study on drug use and HIV/AIDS, Regional Summary, 2007, p. 52.

\(^{1070}\) UNODC, “Strategic program of counteracting the HIV/AIDS epidemic in the system of the Ministry of Health of the Republic of Tajikistan, 2004-2010”, 2004, Section 3.5. Similarly, as noted above, the national “Strategy for counteracting the HIV/AIDS epidemic in the Republic of Tajikistan, 2007-2010” also includes HIV prevention among prisoners.
strategic plan and to the information provided by the national expert group, comprehensive HIV and STI prevention programmes do not exist in all correctional institutions in the country. HIV prevention measures in pre-trial custody institutions and penitentiary institutions currently consist of educational seminars for prisoners and the distribution of condoms and information. The national expert group reports that materials for personal hygiene, including shaving accessories, are distributed (although in insufficient quantities), and disinfectant solutions and sterile medical equipment are available in the first-aid stations.

However, the national expert group's report also raises concerns. Prisoners' access to information materials and peer-to-peer education is limited. There are no programmes providing opioid substitution treatment in prisons, nor programmes to support drug users in achieving abstinence from drugs. There is poor integration of public health services into the prison system, and access to condoms, disinfecting substances, and treatment for prisoners with STIs or HIV infection is not satisfactory.

In the remaining period until 2010, the Ministry of Health plans significant improvements in HIV prevention programmes in all correctional facilities of the country. As the Ministry’s strategic plan indicates, this requires greater coverage and supply of condoms and disinfectants, information, peer education programmes, better access to treatment of STIs, the introduction of substitution treatment in some institutions, and the piloting of needle and syringe programmes in some institutions.

**Health care services in prisons**

The medical department of the penitentiary system, under the Ministry of Justice, is responsible for health care services in institutions of the penitentiary system and in pre-trial detention facilities. Treatment and care of people living with HIV, hepatitis and tuberculosis is provided, including access to antiretroviral therapy (ART), as is voluntary HIV testing and counselling. However, according to the national expert group, medical facilities in pre-trial detention units and penitentiary institutions are not adequately supplied with medical accessories and medicines. According to the Penal Code, prisoners have the right to apply to the system of private medical services. Access to such services and needed medicines is a personal expense to be paid by the prisoner or his or her relatives.

As noted above, the Criminal Code provides for compulsory treatment of people with drug dependence in prisons, concurrently with the sentence of imprisonment. As in other countries of the region, no programmes for diversion of drug dependent offenders into treatment instead of imprisonment exist in Tajikistan (even though providing treatment as an alternative to imprisonment is allowed under the UN drug control treaties). According to the national expert group, treatment for drug dependence is limited in the prison system, consisting solely of detoxification. According to the Penal Code, housing and treatment of prisoners with chronic alcoholism and drug dependence is arranged in special medical penitentiary institutions.

Tajikistan is the only country participating in this project which has included mention of health care in relation to HIV in the penitentiary system in its HIV law. The law stipulates the right of prisoners and detainees with HIV to specific medical assistance, counselling and referral to other support services during imprisonment and detention. Prisoners have the right to confidential testing and counselling based on informed consent. Information about prisoners’ or detainees’ health is to be accessible only to health care staff, and may be disclosed only with the consent of the prisoner or if necessary to ensure the safety of other prisoners and prison staff. The law also prohibits discrimination of prisoners on the basis of their HIV status.

However, the national expert group has noted, with concern, that there are also limitations of the rights of prisoners with HIV or drug dependence.

- For example, according to the Penal Code, prisoners with HIV are to be segregated from the rest.

---

1073 Criminal Code of Tajikistan, Articles 96-101.
1074 Penal Code of Tajikistan (6 August 2001), Article 105, and internal regulations of the penitentiary institutions.
1075 Law on counteracting HIV/AIDS, Article 14-1.
1076 Ibid.
of the prison population, even though HIV is not casually communicable; while it appears that this provision is not generally enforced, it is legislative discrimination that should be repealed. (Prisoners with tuberculosis are segregated, according to the national expert group.)

- When prisoners are transported from one penitentiary facility to another, prisoners with tuberculosis, those who have not completed STI treatment, those with HIV and those with psychiatric disorders are transported separately from the rest.

- According to the Penal Code, after serving either half or one-third of a sentence (depending on the circumstances), a prisoner may be eligible for transfer to a lower-security institution for the remainder of his or her sentence. However, certain prisoners are not eligible for this transfer, including prisoners who have not completed their full term of compulsory treatment and prisoners who require special medical treatment in closed institutions.

- Similarly, prisoners who are deemed to demonstrate sufficiently good behaviour, and prisoners whose work is connected with movement outside of the institution, can be housed in special housing outside the penitentiary (within the borders agreed with the local district administration). This right is restricted for prisoners with HIV, and prisoners who have not completed treatment for alcoholism or drug dependence, STIs or tuberculosis.

In effect, these provisions regularly, and without justification, discriminate against entire categories of people based on their health status, rather than being based on case-by-case assessments of whether such restrictions are justified. They should be repealed.

---

1077 Penal Code of Tajikistan, Article 78.
1078 Ibid., Article 74.
1079 Ibid., Article 80.
1080 Ibid., Article 80(3).
1081 Ibid., Articles 99-100.
6. DISCRIMINATION AND RESTRICTION OF RIGHTS

There is a general rule prohibiting discrimination in the Constitution of the Republic of Tajikistan, which declares that the state guarantees equal rights without regard to nationality, race, sex, language, religion, political beliefs, education, social status or property status. Tajik law also prohibits discrimination, to at least some degree, on the basis of HIV status and on the basis of drug dependence.

The Law on counteracting HIV/AIDS prohibits “dismissal from work, refusal of employment, refusal of enrolment to educational institutions and institutions providing medical aid, and restriction of other rights and legitimate interests of HIV-positive person based on the fact of the infection, or equally, restriction of housing and other rights and legitimate interests of family members of the HIV-infected persons.” The law prohibits discrimination on the ground of HIV status. Any public action with the purpose of inciting hatred and contempt to a person or a group of persons on the basis of actual or presumed HIV status is prohibited. Any limitation of rights and freedoms of people with HIV and AIDS must be justified by preservation of public health or rights and freedoms of others. This amendment introduced in 2008 makes Tajikistan the first country participating in the project to prohibit discrimination on the basis of both actual and presumed HIV-positive status.

The Law on narcological assistance declares that restricting the rights of persons with narcological diseases is not allowed, except for those restrictions provided by national legislation.

In reality however the situation is somewhat different. As noted by the national expert group, despite these prohibitions, discrimination based on HIV-positive status and on drug use is common. In addition, there exist some legislative and policy measures that arguably unjustifiably discriminate against people with HIV and vulnerable groups, including people who use drugs:

- For example, already outlined above are some policies and practices imposing compulsory drug testing and compulsory HIV testing that are not justifiable.
- HIV testing as a condition of employment is rarely justifiable, yet is currently found in Tajik legislation for some individuals. It is not factually sound to assume that a worker is incapable of performing the duties of certain occupations simply because he or she has HIV; therefore, blanket exclusions from holding certain positions are unjustifiable discrimination. Decisions about a person’s competence to perform work should be made on an individual basis, not based on HIV status. International guidance in this area establishes that:

  The right to work entails the right of every person to access to employment without any precondition except the necessary occupational qualifications. This right is violated when an applicant or employee is required to undergo mandatory testing for HIV and is refused employment or dismissed or refused access to employee benefits on the grounds of a positive result. States should ensure that persons living with HIV are allowed to work as long as they can carry out the functions of the job. Thereafter, as with any other illness, people living with HIV should be provided with reasonable accommodation to be able to continue working as long as possible and, when no longer able to work, be given equal access to existing sickness and disability schemes. The applicant or employee should not be required to disclose his or her HIV status to the employer nor in connection with his or her access to workers’ compensation, pension benefits and health insurance schemes. States’ obligations to prevent all forms of discrimination in the workplace, including on the grounds of HIV, should extend to the private sector.

- In addition, there is a list of certain kinds of trades and activities, considered to be higher-risk, from

1082 Constitution of the Republic of Tajikistan, Article 17.
1083 Law on counteracting HIV/AIDS, Article 13 (as amended in 2008).
1084 Law on narcological assistance, Article 8.
which someone may be barred based on drug use without a consideration of the individual case. For example, a diagnosis of drug or alcohol dependence can be a basis for automatically denying someone a driver’s license. In addition, people with drug dependence are prohibited from certain kinds of employment that carries increased risk.

- HIV-positive status and drug dependence can also affect familial rights and responsibilities under Tajik law. According to a government resolution, HIV and drug dependence are included on a list of diseases that constitute grounds for denying someone’s application to adopt a child. The explicit reference to the health condition of alcoholism or drug dependence as a factor akin to mistreating a child mean that parents are vulnerable to losing their children if such a diagnosis is per se, seen as adequate basis for such an order. The Family Code also releases a person from the legal duty to support his or her spouse if the spouse’s disability results from abusing alcohol or narcotics. If one of the would-be spouses concealed from another an STI or “AIDS disease”, another spouse has right to demand annulment of the marriage. One of the grounds impeding marriage is limitation of legal capacity by a court on the basis of one’s misuse of alcohol or drugs.

According to principles well established in international human rights law, limitations or infringements on human rights may only be justified in accordance with clear standards. One key principle is that of non-discrimination, including based on health status. It will be the very rare case in which denying certain rights or benefits to entire classes of persons based on their health status (e.g., diagnosis with HIV infection or drug dependence) will be justifiable. Rather, discriminating in employment or denying parental rights should require case-by-case justifications, based on an assessment of individual circumstances, rather than based on inaccurate, generalized assumptions about a person’s capacity to perform the functions of a job or to be a suitable parent based on health status.

1086 Government of the Republic of Tajikistan, Resolution “On adopting a list of diseases in the presence of which one cannot adopt or receive custody of a child”, Resolution No. 406 (1 October 2004). Drug dependence, HIV, TB and oncological diseases are on the list.
1087 Family Code of the Republic of Tajikistan (version of 29 April 2006 # 183, last amended 20 March 2008), Article 69.
1088 Family Code of the Republic of Tajikistan, Article 93.
1089 Family Code of the Republic of Tajikistan, Article 15(3).
1090 “Legal capacity” could be “limited” or “repealed” (cancelled) by court. Limitation of legal capacity is done following an application of relatives or government agencies is a person “puts him/her self or his/her family in difficult economic situation, because of abuse of alcohol or drugs”. (Civil Code of the Republic of Tajikistan, last amended 1 March 2005, No. 85, Article 31).
The recommendations below are aimed at addressing issues identified by the national expert group of Tajikistan and by the project's technical advisors. The national expert group also drafted a series of specific amendments to the Law on counteracting HIV/AIDS which it proposes; these are reproduced, as developed by the national expert group, in the Appendix below. Suggested language of legislative amendments is shown in shaded boxes.

National programmes and strategies

Recommendation 1: Ensuring attention to and involvement of vulnerable groups

In the interests of being more inclusive, and hence better informed and more effective, national programmes and strategies on HIV/AIDS and on drugs should explicitly guarantee:

- attention to HIV prevention, care, treatment and support for vulnerable groups, including people who use drugs and prisoners, among others; and
- the involvement of non-governmental organizations, people living with HIV, people who use drugs, and members of other vulnerable groups.

Administrative and criminal law issues

Recommendation 2: Repeal unnecessary, un-enforced prohibition on drug consumption

As noted above, the Law on narcotics, psychotropic substances and precursors (Article 15) currently states a prohibition on consumption of such substances without a prescription, but nothing in this or another law imposes a penalty. This provision serves no purpose but to stigmatize people with drug dependence; it is recommended that Article 15 be repealed.

Recommendation 3: Consider reducing penalties on possession of small quantities of drugs without intention to sell

As noted above, under the Administrative Code (Article 42), possession of drugs without an intention to sell attracts only administrative liability, punishable by a fine, in the case of very small quantities falling below the "small" [мелкие] quantities that can trigger criminal liability (e.g. less than 0.5g in the case of heroin). In this regard, Tajik law sets a positive example by eliminating criminal penalties in some circumstances of possessing minimal quantities of drugs without intention to sell. However, in many cases, Tajik law still imposes quite harsh penalties for possession of drugs even where there is no intent to sell. In the case of “small” minimal [мелкие] quantities (0.5-10g of heroin), while the penalty for a first offence may be limited to a fine, it could also carry a penalty of imprisonment for up to two years. In the case of a “minor” [небольшие] quantity (10-100g of heroin), the punishment for a first offence is from two to five years. The penalty for any subsequent offences, after a first offence, committed by group of people or in a prison, is a minimum penalty of five years, and up to a maximum of 8 years, and possibly confiscation of property as well — even if the possession still only involved “small” or “minor” quantities. Given the nature of drug dependence as a chronic, relapsing condition, criminalizing repeated possession of even small and minor quantities of a prohibited drug, even without intention to sell, criminalizes people with drug dependence. The Government of Tajikistan should consider entirely removing criminal penalties for possession of small quantities where there is no intention to sell. This could be achieved by enacting a provision such as the following in the Criminal...
Code (and in the Administrative Code as well should the decision be made to remove administrative penalties as well for possession of small quantities without intention to sell): 1093

Decriminalization [or depenalization] of possession without intention to sell

The use and possession of a controlled substance in a small quantity with no intention to sell does not attract a criminal penalty [nor does it attract an administrative penalty].

Recommendation 4: Clear legislative framework for needle and syringe programmes

With the objective of supporting effective HIV prevention among injection drug users and protecting the public health more generally, the national expert group has recommended creating a clear legislative framework for needle and syringe programmes, including the disposal of used syringes. Wording of legislative provisions such as the following could be introduced to the existing Law on counteracting HIV/AIDS or other suitable legislation: 1094

Sterile syringe programmes

1. “Sterile syringe programme” means a programme that provides access to sterile syringes and other related material, information on HIV transmission and other blood-borne pathogens, or referrals to substance abuse treatment services. It includes needle exchange programmes, needle distribution programmes and other forms of sterile syringe distribution.

2. Staff of the sterile syringe programme may provide a range of material and services, including the following:
   a) sterile syringes and other related material for safer injection drug use, including sterile water ampoules, swabs, filters, safe acid preparations, spoons and bowls and other appropriate materials;
   b) material to enable safer smoking and inhalation of drugs, such as pipes, stems, metal screens, alcohol wipes and lip balm;
   c) condoms and other safer sex materials, such as water-based lubricants and dental dams, as well as information about reducing the risks of HIV and other sexually transmitted infections; and
   d) first aid in emergency situations.

3. Staff of sterile syringe programmes may provide information including, but not limited to, the following:
   a) drug dependence treatment services and other health services;
   b) means of protection against transmissible diseases, including blood-borne diseases such as HIV;
   c) the risks associated with the use of controlled substances;
   d) harm reduction information specific to the drug being used, including safe injecting and inhaling practices;
   e) legal aid services;
   f) employment and vocational training services and centres; and
   g) available support services for people with drug dependence and their families.

4. The state shall ensure access to sterile syringes for people who require them. Where sterile syringes are not otherwise available and there is demand, the state shall establish a sterile syringe programme out of public funds. The state may distribute sterile syringes through public health facilities or provide funding to community organizations to operate sterile syringe programmes.

Recommendation 5: Precluding criminal or administrative liability for harm reduction programmes

The harm reduction and outreach activities of non-governmental organizations targeting people who use drugs, such as programmes providing sterile syringes or other equipment to reduce harms associated with drug use (including HIV transmission), should be clearly exempt from possible liability. In particular, they should be exempt from liability under Article 203 (“involvement in drug use”) or Article 205 (“organizing a site for drug consumption”) of the Criminal Code, or under Article 42.1 of the Code of Administrative responsibility for “possession” of residual quantities of drugs in used injection or other equipment. Specific legislative provisions such as the following could achieve this:1095

Exemption from criminal liability for sterile syringe and other harm reduction programmes

Nothing in the Criminal Code or other law prevents the supply of sterile syringes and other related material, or the giving of advice, information or instruction on the safe use of syringes and other related material, by staff of a sterile syringe programme or other programme aimed at reducing harms associated with the use of prohibited narcotics or psychotropic substances. For greater clarity, any prohibition in the Criminal Code or other law on “involvement in drug use” does not apply to providing equipment and information on drug use for the purpose of preventing the spread of HIV and other blood-borne infections or other injuries or harms that may be associated with drug use.

No penalty for possession of residual amounts of substances in drug use equipment

A person who is in possession of any residual amount of a prohibited narcotic or psychotropic substance that is contained in or on a syringe or other equipment used to ingest such a substance does not, by the mere fact of that possession, commit an offence under any law.

Recommendation 6: Eliminate unjustifiably broad provisions for compulsory drug testing

Currently, Article 16 of the Law on narcotics, psychotropic substances and precursors authorizes compulsory drug testing on the basis of sufficient grounds to believe that a person has consumed illegal drugs, even though drug use is not a criminal or administrative offence in itself. In addition, Article 18 of the Law on narcological assistance currently states that: “Where there are grounds to believe that a person suffers from drug dependence, alcoholism, is under the influence of alcohol or narcotics, or has used a narcotic or psychotropic substance without a prescription from a medical doctor, the person may be referred for physical examination.”1096 As outlined above, such provisions infringe numerous human rights. Among other things, compulsory drug testing violates privacy and security of the person, without justification in most circumstances, since merely showing past use of drugs does not prove there is a risk of harm to self or others, which should be the only basis for possibly justifying an intrusion by the state into such rights. To eliminate unjustifiably broad provisions for compulsory drug testing, it is recommended that the Parliament of Tajikistan repeal Article 16 of the Law on narcotics, psychotropic substances and precursors and Article 18 of the Law on narcological assistance.1097

Recommendation 7: Decriminalise sex work

It is recommended to repeal Article 174.1 of the Administrative Code of Tajikistan (sex work). The International Guidelines on HIV/AIDS and Human Rights recommend that with regard to adult sex work that involves no victimization, criminal law should be reviewed with the aim of decriminalising and legally regulating occupational health and safety conditions to protect sex workers and their clients, including


1096 Law on narcological assistance, Article 18.

1097 It should be noted that involuntary intervention in cases where a person is at risk of being harmed, or harming others, as a result of drug dependence would still be possible under the terms of Article 9 of the Law on narcological assistance.
support for safe sex during sex work. Articles 238-239 of the Criminal Code are sufficient for punishing criminal behaviour in relation to sex work.

**Recommendation 8: Eliminate HIV and STI-specific criminal law**

Articles 125 and 126 of the *Criminal Code*, which specifically provide for punishment for transmission and exposure to “venereal diseases” and HIV, should be repealed. In the case of intentional transmission of venereal or HIV infection, this could be dealt with as infliction of bodily harm that is covered by other articles of the *Criminal Code*.

**Drug dependence treatment**

**Recommendation 9: Implement opioid substitution treatment**

Methods of drug dependence treatment need to be expanded and brought in line with international standards and good practice. It is recommended that the Ministry of Health introduce OST programmes immediately. As noted above, opioid substitution treatment is permitted under existing Tajik legislation, and is supported in both the national AIDS programme and a Ministry of Health order. Implementation of OST programmes should not be delayed; small-scale pilot projects approved in 2008 should proceed and be scaled-up. Additional legislation is not needed to move ahead with this important health service, which is critical to drug dependence treatment and to HIV prevention among people who inject drugs. Although not necessary, it may be useful to help support and sustain this programme to have a clear legislative basis, in which case an additional step could be to amend the *Law on narcological assistance* to add some provisions providing a clear framework for substitution therapy, one that protects and promotes the human rights of patients receiving OST.

**Recommendation 10: Reform the system of registration of people who use drugs**

In order to protect and respect human rights, and to remove reason for people to avoid seeking out treatment for drug dependence or help with problematic drug use, Tajikistan should abolish a central registry of people who use drugs and are dependent on it, which registry is then used in ways that can infringe human rights. To this end, the relevant paragraph of Article 14 of the *Law on narcological assistance* should be amended to repeal the provision on registration of people who use drugs; the relevant provisions of the Order of the Ministry of Health that implement such a registry should also be amended. (Obvi-...)

**Recommendation 11: Provide for full confidentiality of health information of people who use drugs**

As noted above, currently the *Law on narcological assistance* mandates that narcological institutions must “cooperate” with law enforcement bodies (Article 22) and also requires that they disclose, upon receipt of a written request, information about a person’s drug dependence to various bodies, including the public prosecutor and judicial and investigative bodies (Article 21). Information exchange and cooperation between law enforcement bodies and the medical institutions engaged in treatment of drug dependence should be limited by law. Routine disclosure of such personal information, including health information, to law enforcement bodies undermines patients’ trust in medical workers and drives them away from seeking medical services, including treatment for drug dependence. It is recommended that these...
articles be amended to narrow significantly the scope of “cooperation” by narcological centres with law enforcement authorities and the requirement to disclose confidential health information.

Specifically, these articles in the Law on narcological assistance should be amended so as to permit (but not require) health professionals of such narcological centres to breach patient confidentiality only in circumstances where health professionals believe, in good faith and on reasonable grounds, that doing so is necessary to prevent imminent, serious harm to a patient or to another person. Additionally, health professionals should be required to share confidential information with law enforcement bodies only following court order. All other instances of sharing information should be prohibited.

In addition, the Law on narcological assistance should also be amended to include explicit provisions strengthening the confidentiality of health information of patients receiving narcological assistance. Provisions such as the following should be added to the legislation:1101

(1) The confidentiality of all health care information shall be respected. Records of the identity, diagnosis, prognosis or treatment of any patient which are created or obtained in the course of drug dependence treatment:
   a) are confidential;
   b) are not open to public inspection or disclosure;
   c) shall not be shared with other individuals or agencies without the consent of the person to whom the record relates; and
   d) shall not be discoverable or admissible during legal proceedings.

(2) No record referred to in Section (1) may be used to
   a) initiate or substantiate any criminal charges against a patient; or
   b) act as grounds for conducting any investigation of a patient.

(3) Programme staff cannot be compelled under any other law to provide evidence concerning the information that was entrusted to them or became known to them in this capacity.

(4) All use of personal information of patients and programme staff in research and evaluation shall be undertaken in conditions guaranteeing anonymity, and any such information shall also be governed by Section (2) of this article.

Recommendation 12: Reform legislation on compulsory drug dependence treatment
According to the national expert group, the Law on compulsory treatment of people with alcoholism and drug dependence, which is not implemented, should be repealed so as to abolish the possibility of compulsory treatment of drug dependence being applied to any person. As noted above, involuntary medical interventions are, absent some very clear and strong justification, a violation of basic human rights recognized in international law. At most, compulsory treatment for persons who are confirmed to be drug dependent (and not simply casual drug users) can only be justified as a last resort, in exceptional circumstances.1102

In addition, as noted above, the Criminal Code currently states that, in cases where a narcological exam establishes addiction, a person convicted of an offence will be subject to compulsory drug dependence treatment in addition to imprisonment. It is recommended that, in conformity with the international drug control treaties, the Criminal Code should be amended to allow such drug dependence treatment to be an alternative to imprisonment in at least some cases, rather than an additional sentence.

Recommendation 13: Implement programmes on overdose prevention and management
In order to prevent deaths and other serious harms from overdoses among opioid users, outreach workers (including those working for non-governmental organizations and including “peers” who are themselves persons who use or have previously used drugs), should be given the legal right to distribute and

1102 Recall that the separate Law on narcological assistance already has some specific provisions about circumstances in which a person may be involuntarily hospitalized in a narcological centre out of concern for his or her health or that of others (Article 9).
administer medications such as naloxone in cases of overdose. This could be done by introducing provisions such as the following into the *Law on narcological assistance*:\textsuperscript{1103}

**Outreach to people who use drugs**

(1) “Outreach work” means a community-oriented activity undertaken to contact and provide information and services to individuals or groups from particular populations at risk of blood-borne diseases, particularly those who are not effectively contacted or reached by existing information and services or through traditional health care channels.

(2) “Outreach workers” include paid social or public health workers or unpaid volunteers (including peers) of governmental or non-governmental facilities.

(3) Outreach workers may include people who currently use drugs, people who formerly used drugs or people who do not use drugs and are trusted by people who use drugs.

**Administration of an opioid antagonist**

(1) The Ministry of Health must make provision for the appropriate training of outreach workers in the administration of opioid antagonists.

(2) An outreach worker may administer an opioid antagonist to another person if:
   a) the worker believes, in good faith, that the other person is experiencing a drug overdose; and
   b) the worker acts with reasonable care in administering the drug to the other person.

(3) An outreach worker who administers an opioid antagonist to another person pursuant to Section (1) shall not be subject to civil liability or criminal prosecution as a result of the administration of the opioid antagonist.

In order to preclude overdose complications in prisons, it is recommended to allow peer educators among prisoners and prison staff to administer naloxone in case of overdose in penitentiary institutions, and train them to use this emergency response medication.

**HIV prevention and treatment**

**Recommendation 14: Strengthening harm reduction measures**

As noted above, in 2008 amendments to the *Law on counteracting HIV/AIDS* were enacted, which included an article proclaiming the government priority of HIV prevention, based on human rights principles and taking into account UN recommendations.\textsuperscript{1104} This is a welcome development, but in order to further strengthen prevention, Tajik legislators might consider legislatively mandating measures to reduce harms, including HIV infection, among people who use drugs and prisoners. This should include directives specifically to government bodies and agencies that have particular responsibilities in this area, such as the Ministry of Health and Ministry of Justice, as well as clearly directing law enforcement bodies (e.g., the Drug Control Agency) to cooperate with other government bodies and with non-governmental organizations to ensure the effective delivery and operation of harm reduction services (e.g., sterile syringe programmes, OST).

**Recommendation 15: Ensuring informed consent to HIV testing**

The national expert group has reported that welcome steps are being taken to ensure a clear legal requirement to ensure people give consent to HIV testing that meets the requirements of informed consent, and that testing be accompanied by pre- and post-test counselling. While the details could be set out in

---


\textsuperscript{1104} *Law on counteracting HIV/AIDS*, Article 6-1.
different instruments (e.g., a regulation or order from the Ministry of Health), it would also be advisable to include, in the Law on counteracting HIV/AIDS, a provision along the lines of the following:

No test for HIV or other blood-borne infection shall be undertaken except with the informed voluntary consent of the person being tested, which informed consent should be clearly documented in writing.

**Recommendation 16: Eliminating inconsistency and the infringement of human rights as relates to compulsory testing and treatment for HIV and STIs**

The current Law on counteracting HIV/AIDS states the general principle that HIV testing should be voluntary and the Law on public health care also recognizes a general right to refuse medical examination and treatment. However, current Tajik law also contemplates numerous unwarranted exceptions to this principle, including other provisions in the Law on public health care that allow compulsory testing and treatment, as well as possible administrative or criminal liability for refusing or evading testing and treatment, in the case of various diseases, including HIV. This inconsistency, and the infringement of human rights reflected in compulsory medical interventions, should be addressed through legislative reforms to comply with international guidelines. Specifically:

- Articles 40, 42 and 67 of the Law on public health care should be amended to clarify that testing and treatment for HIV and other STIs cannot be imposed involuntarily simply by request of the public health services. Rather, if testing or treatment is ever to be imposed without consent, then it requires a process clearly set out in law, with a requirement that such measures be taken only in exceptional circumstances and with adequate justification that must be considered by an independent, judicial body, and with the most limited infringement of human rights possible.1105

- Article 40 of the Law on public health (“Responsibility of people to follow physician’s orders”) according to which not following a physician’s orders is considered avoiding treatment and leads to legal liability, should be removed. In addition, the following provisions authorizing compulsory testing and treatment should be repealed: Article 42 of the Law on public health (“Responsibility of people with TB, leprosy, AIDS and venereal diseases”) authorizing compulsory testing and treatment upon demand by public health authorities; Article 67 of the Law on public health, according to which people with AIDS and venereal diseases who avoid treatment are legally liable; and provision of the Code of Administrative Responsibility, providing for liability for avoiding treatment and testing.

**Recommendation 17: Providing for protection of other patient rights**

While the Law on public health care currently recognizes some important rights of patients, it should be strengthened — to the benefit of all patients, and not just those with HIV, STIs or drug dependence — by explicitly adding provisions such as the following to Article 31.1106

Every patient has the right:

a) to treatment and provided in accordance with good clinical practice;
b) to treatment without discrimination;
c) to meaningful participation in determining his or her own treatment goals;
d) to meaningful participation in all treatment decisions, including when and how treatment is initiated and withdrawal from treatment;
e) to exercise his or her rights as a patient;
f) to confidentiality of medical records and clinical test results; and

1105 Guidelines such as the UN’s Siracusa Principles on permissible limitations on human rights should be complied with in any legislative provision that would allow involuntary testing or treatment. It is worth noting that the Law on public health care (Article 31) already recognizes that a patient should have the right to a lawyer or other representative to help ensure protection of his or her rights, so introducing amendments designed to strengthen the human rights not to be subjected to compulsory testing or treatment should build on that.

g) to be fully informed, including but not limited to the right to receive information about:
   i) his or her state of health;
   ii) his or her rights and obligations as a patient, as specified in any applicable law;
   iii) the procedure for making a complaint about health services received; and
   iv) cost and payment conditions and the availability of medical insurance and other possible subsidies.
   v) to decline treatment and testing

**Prisons**

**Recommendation 18: Provide access to voluntary drug dependence treatment, including OST in prisons**

Given the high prevalence of drug dependence among those imprisoned, the significance of risky drug use practices in contributing to the HIV epidemic, and the importance of providing access to health services that respect human rights and help promote the highest attainable standard of health for all persons, it is recommended that Tajikistan implement voluntary drug dependence treatment programmes in prisons. As OST is made available outside prisons, it should similarly be made available inside prisons as one important element of programmes for addressing drug dependence.

To this end, if amendments are introduced to the *Law on narcological assistance* so as to create a clear legal framework for substitution therapy that protects and promotes the human rights of patients receiving OST (as suggested above in Recommendation 6), those amendments should include explicit reference to providing access to OST to drug-dependent persons in prisons. Such a provision could be worded as follows (and could also be inserted into legislation such as the *Penal Code*):

1107

**Opioid substitution treatment programmes in prison**

(1) The Ministry of Health, with the support and cooperation of the Ministry of Justice, shall establish opioid substitution treatment programmes in all prisons.

(2) Prisoners with opioid dependence shall be eligible for opioid substitution treatment in accordance with opioid substitution treatment guidelines applicable in the community.

(3) Opioid substitution treatment shall be available for free on imprisonment and throughout the duration of imprisonment.

(4) Opioid substitution treatment shall not be restricted to those on a course of opioid substitution treatment prior to imprisonment; all prisoners shall be entitled, if eligible, to being on opioid substitution treatment while incarcerated.

(5) Participation in the opioid substitution treatment programmes shall be offered on a voluntary basis to all prisoners with opioid dependence.

(6) Opioid substitution treatment programmes may include a variety of approaches, including maintenance treatment.

(7) The programme shall ensure that staff members, prison officers, policy makers and prisoners have factual information regarding opioid substitution treatment.

(8) The programme shall develop a comprehensive discharge planning system for prisoners nearing release, including a system for referral to opioid substitution treatment programmes in the general community.

Recommendation 19: HIV prevention in prisons and detention facilities

In order to strengthen HIV prevention efforts in prisons and pre-trial detention facilities, legislative amendments could mandate the introduction of harm reduction programmes in prisons. Internal regulations of penitentiary institutions should be revised to strengthen HIV prevention among prisoners, including by ordering measures to ensure access to bleach and sterile syringes, as well as ensuring access to condoms, and information related to risks of HIV transmission through unsafe sex or drug use. The Internal Regulations’ provisions prohibiting prisoners from possessing needles and syringes should be removed, as these represent a barrier to implementing needle and syringe programmes in prisons. Provisions such as the following could be inserted into the Law on counteracting HIV/AIDS and/or the Penal Code:1108

**Distribution and possession of condoms and other safer sex materials in prisons**

(1) The Ministry of Health and the Ministry of Justice shall ensure that condoms and other safer sex materials, along with appropriate information on their proper use and on their importance in preventing the spread of HIV infection and other sexually transmitted infections, are made available and easily accessible to prisoners in a manner that protects their anonymity.

(2) The Ministry of Health shall develop a plan for the disposal of used condoms that protects the anonymity of prisoners and the health of prison officers.

(3) The distribution and possession of condoms and other safer sex materials in prisons in accordance with this law shall not constitute a criminal nor administrative offence, nor are condoms and other safer sex materials admissible as evidence of sexual relations for the purposes of determining any criminal or administrative offence.

**Authorization of harm reduction programmes**

(1) Harm reduction programmes shall be implemented in all prisons according to the provisions set out herein, with the objective of reducing harms associated with unsafe use of drugs, including the risk of transmission of HIV or other blood-borne diseases.

(2) In order to prevent the spread of blood-borne diseases and minimize the health risks associated with drug use by prisoners, either the Ministry of Health or a local prison authority may authorize a specified person or organization (including non-governmental organisations) to deliver harm reduction programmes, including measures to supply sterile syringes and other related material to prisoners, as well as condoms and other materials to reduce the risks of HIV and other sexually transmitted infections.

**Information**

Staff of harm reduction programmes may also provide information including, but not limited to, the following:

(a) drug dependence treatment services and other health services;
(b) means of protection against transmissible diseases, including blood-borne diseases such as HIV;
(c) the risks associated with the use of controlled substances;
(d) harm reduction information specific to the drug being used, including safe injecting and inhaling practices;
(e) legal aid services;
(f) employment and vocational training services and centres; and
(g) available support services for people with drug dependence and their families.

**Distribution and possession of sterile syringes and related material**

(1) An authorized person or organization may distribute sterile syringes and related material via one or more of the following means:

---

(a) prison nurses or physicians based in a medical unit or other area(s) of the prison;
(b) prisoners trained as peer outreach workers;
(c) non-governmental organizations or health professionals who enter the prison for this purpose;
(d) one-for-one automated sterile syringe-dispensing machines.

(2) Wherever possible, sterile syringes and related material shall be made available to prisoners without the necessity of the prisoner identifying himself or herself to prison authorities.

(3) The Ministry of Justice, in consultation with the Ministry of Health shall establish rules for the safe storage of syringes possessed by prisoners in accordance with this law.

(4) The sterile syringe programme shall include measures to encourage safe disposal of syringes and monitor the number of syringes distributed and the number in storage.

(5) Sterile syringes and related material distributed by harm reduction programmes shall be used only in accordance with this law and any other applicable Regulations or institutional policies established by the relevant authority.

(6) The distribution and possession of syringes and related material in prison in accordance with this law shall not constitute a criminal nor administrative offence, nor shall such items be admissible as evidence of illegal drug use for the purposes of determining any criminal or administrative offence.

Availability of bleach as a disinfectant

(1) Bleach and instructions on using bleach as a disinfectant shall be made available in accordance with this law and any other applicable Regulations or institutional policies established pursuant to this law.

(2) Any such Regulations or policies established pursuant to Section (1) will:
   (a) encourage participation of prisoners and their assistance in bleach distribution;
   (b) ensure that bleach is available to prisoners in ways that preserve prisoners’ anonymity; and
   (c) ensure that in no instance shall a prisoner be required to approach a staff member in order to obtain bleach.

(3) Bleach distributed pursuant to this law shall be used only in accordance with this law and any other applicable Regulations or institutional policies established pursuant to this law.

(4) The distribution and possession of bleach in prison in accordance with this law shall not constitute a criminal nor administrative offence, nor shall such items be admissible as evidence of illegal drug use for the purposes of determining any criminal or administrative offence.

Information and education programmes regarding HIV/AIDS, other blood-borne diseases and drug dependence treatment in prisons

(1) The Ministry of Health shall develop and implement information and education programmes in every prison to help prevent the spread of HIV, other blood-borne diseases, and to address drug dependence among prisoners.

(2) In developing such programmes, the Ministry of Health shall use materials that are likely to be effective in reducing transmission of blood-borne diseases within prisons and outside prison following the release of prisoners, as well as providing information on treatment, care and support.

(3) Such programmes required by Section (1) may include peer education and use of non-Ministry of Justice personnel, including delivery of these programmes by community-based organizations.

(4) Materials shall, as much as possible, be available in the languages of the relevant populations,
shall take into account the literacy level of the relevant populations, and shall be sensitive to the social and cultural needs of the relevant populations.

**Responsibility of the Ministry of Health for providing training and education**

The Ministry of Health is responsible for ensuring:

(a) that training and education are provided to staff and prisoners on a regular basis, and that such training and education include the principles of standard precautions to prevent and control blood borne diseases; the personal responsibility of staff and prisoners to protect themselves and others at all times; and information on post-exposure prophylaxis, if available;

(b) that training and education provided to prisoners also include available services and treatments; and peer education and counselling programmes that include the meaningful participation of prisoners as counsellors; and

(c) that prisoners and staff who may be exposed to blood and body fluids receive training in universal precautions.

**Recommendation 20: Eliminating discrimination against prisoners with HIV or drug dependence**

To eliminate discrimination currently embedded in the law, the **Penal Code** should be amended in a number of ways, as follows:

- Repeal the prohibition on transferring prisoners who are ordered to undergo compulsory drug dependence treatment to better conditions (lower security institutions).
- Remove HIV-positive status and the fact of not completing a full course of treatment for drug dependence or STIs from Articles 80 and 100 (and others as follows) as factors that restrict a prisoner’s right to transfer and movement.
- Although it is reportedly not enforced at the moment, Article 78, which provides for the segregation of HIV-positive prisoners, is discriminatory and should be abolished.

**Discrimination**

As noted above, current Tajik law includes very important provisions prohibiting, in general terms, discrimination against people based on actual or perceived HIV-positive status1109 and drug dependence.1110 Yet at the same time, discrimination is a reality and Tajik law itself contains discriminatory provisions in other areas. Legal protections against discrimination are important elements of successfully addressing the marginalization that contributes, in multiple ways, to people's vulnerability to HIV and to experiencing even more severely the impact of HIV infection. Tajik law can be strengthened in several ways in this regard in order to comply with human rights principles.

**Recommendation 21: Eliminating HIV testing in employment or educational settings**

Current Tajik law already prohibits refusing to employ someone or dismissing someone from employment based on HIV status. However, it would be useful to recognize explicitly that requiring HIV testing before or during employment or attendance at an educational institution amounts to unjustified discrimination.1111 A legislative amendment to the **Law on counteracting HIV/AIDS** should prohibit such practices. A

1110 Law on narcological assistance, Article 8.
1111 E.g., see UNAIDS/OHCHR, *International Guidelines on HIV/AIDS and Human Rights*, para. 149. Similar analysis would apply to discrimination against someone based on something like infection with hepatitis B or C virus (HBV, HCV) or on the basis of a sexually transmitted infection. Given modes of transmission, many people who inject drugs are vulnerable to infection with other blood-borne diseases such as HBV or HCV, in addition to HIV, and may face discrimination on that basis, as has been observed in other jurisdictions. In making amendments to strengthen protection against HIV-related discrimination in an area such as employment or educational contexts, it would be advisable to explicitly include protection against discrimination based on such other diseases.
provision could be worded as follows:

Discriminating against a person on the basis of his or her HIV infection or AIDS diagnosis is prohibited, including but not limited to such contexts as employment or education. It is unlawful discrimination to require that a person be tested for HIV as a condition of employment or enrolment in an educational institution, either before or during employment or enrolment.

Recommendation 22: Eliminating discrimination against drug-dependent persons in employment or educational settings

Requiring drug testing before employment or enrolment in an educational institution is also unjustified discrimination based on health condition. Requiring testing for drug use during employment may only be potentially justifiable in quite limited circumstances, such as limiting testing to positions that are safety-sensitive and then only in cases where there are reasonable grounds to suspect impairment or possibly random drug testing of persons returning to work after receiving drug dependence treatment. It is recommended that the law (perhaps the Law on narcological assistance) be amended to include a provision along the lines of the following: 1112

Discrimination based on drug use

(1) Absent a reasonable justification given the circumstances of the case, it is prohibited to discriminate against a person, or a relative or associate of the person, on the ground that the person uses or has used drugs, or is perceived to use or have used drugs.

(2) It is unlawful discrimination to require that a person undergo drug testing as condition of enrolment in an educational institution, either before or during enrolment.

(3) It is unlawful discrimination to require that a person undergo drug testing as a pre-condition of employment. Making drug testing a condition of continued employment is permitted only in positions, as designated by [suitable government authority], where impairment while at work may pose a significant risk of harm to the individual employee or to others and where there are reasonable grounds to suspect that the individual employee may be impaired by drug use.

Recommendation 23: Respecting and protecting family relationships

The Law on counteracting HIV/AIDS prohibits restricting the “rights and legitimate interests” of people with HIV based on HIV-positive status and “equally, restriction of housing and other rights and legitimate interests of family members of the HIV-infected persons”. 1113 Yet, as noted above, current law states that mere HIV-positive status1114 can be a basis for denying someone’s application to adopt; this blanket discrimination simply on the basis of a health condition, without regard for individual circumstances, is not justified. Similarly, it is of concern that, in cases of concern about child abuse or neglect, drug dependence could be assumed to be per se a sufficient basis to deprive someone of parental rights. In light of this:

- Articles 69 and 14(5) of the Family Code should be amended to clarify that, in cases of concern about child abuse or neglect, drug dependence should not be assumed to be per se sufficient grounds to deprive someone of parental rights, but rather than a careful analysis of the individual circumstances is required. In addition, the limitation of the right to marry based on drug dependence should be removed.
- The government resolution that lists HIV and drug dependence as barriers to adopting or receiving custody of a child should be amended to delete these conditions from the list.

TURKMENISTAN: SUMMARY REPORT AND RECOMMENDATIONS

1. BACKGROUND

Turkmenistan, with a population of more than 6 million, is a country with a very low prevalence of HIV according to official statistics: as of December 2007, official reports indicated only two cases of HIV infection to date.1115 However, the number of people who use drugs is considerably higher: on the basis of the data from the narcological service, as of December 2007, there were 33,000 registered drug users.1116 According to the UNODC, the rate of newly registered drug users was 32.5 per 100,000 people.1117 The need for HIV prevention efforts, among both vulnerable groups and the population as a whole, has been recognized.

1115 UNAIDS, 2008 Report on the global AIDS epidemic (Geneva, 2008), Annex 1. This information is supported by the information presented by the experts.
1117 Ibid.
2. NATIONAL PROGRAMMES AND STRATEGIES

Programme on HIV/AIDS
In 2005, the Cabinet of Ministers approved the "National Programme on the Prevention of HIV/AIDS and STIs in Turkmenistan for 2005-2010".\textsuperscript{1118} The programme was developed by the Inter-agency Coordinating Committee on the Prevention of HIV/AIDS/STDs (ICC). Responsibility for its implementation was assigned to the Ministry of Health and Medical Industry. There is also a "National Programme on the Prevention and Treatment of Tuberculosis for 2005-2009".\textsuperscript{1119}

Stated key activities of the national HIV/AIDS and STI programme include:

- educating the public, youth, military personnel, health care workers, prisoners, people who use drugs, students, sex workers about HIV and STI prevention measures;
- treatment and rehabilitation of persons with narcotics addiction;
- provision of medical aid to people with HIV and their families;
- implementing HIV and STI prevention efforts among prisoners, including providing information and other educational actions, and distribution of condoms;
- improving professional skills of experts in the fields of prevention and HIV/AIDS treatment;
- training doctors and experts to provide HIV testing and pre-and post-test counseling at anonymous testing sites, HIV prevention centres and STI clinics;
- training people who use injection drugs as volunteers to deliver "peer-to-peer" HIV and STI prevention education and services; and
- preventive interventions for sex workers.

The programme does not contain any anti-discrimination provisions or provisions to protect the confidentiality of people living with HIV and STI. Instead, the programme provides for HIV and STI testing of those with drug dependence, and obligatory HIV and STI testing of pregnant women, provisions which raise human rights and public health concerns (addressed in more detail below).\textsuperscript{1120} There is no specific legislative provision on the involvement of NGOs, persons living with HIV or persons who use drugs in work of bodies on HIV/AIDS. However, the national expert group states that there are no restrictions on activities of NGOs in the field of HIV prevention and consumption of drugs, including in institutions of the penitentiary system.\textsuperscript{1121}

The national expert group has recommended that, in order to improve the effectiveness of the National Programme, there should be: closer cooperation with civil society organizations; better coordination of the activities of state and non-state stakeholders; better financing for the programme's activities; and more highly qualified experts.

Programme on narcotic drugs
In 2006, the Government of Turkmenistan adopted a "National Programme on Counteracting Drug Trafficking and Assistance to Persons with Addiction to Narcotics and Psychotropic Drugs for 2006-2010".\textsuperscript{1122} The programme was developed by the State Steering Committee to combat drug dependence (under the Cabinet of Ministers), which Committee includes representatives of law enforcement bodies and the system of public health services. The Committee coordinates all actions directed at countering drug trafficking, as well as prevention and treatment of narcotic addiction, and has supervisory functions over

\textsuperscript{1118} The program was approved by an order of the Vice-Chairman of the Cabinet of Ministers of Turkmenistan, Order No. БГ/05 (27 April 2005).

\textsuperscript{1119} The program on prevention and treatment of tuberculosis was approved by the order of the Vice-Chairman of the Cabinet of Ministers of Turkmenistan, Order No. БГ/02 (13 April 2005).

\textsuperscript{1120} The national expert team has noted that international guidance, including from United Nations agencies working in the field of HIV and AIDS, recommends generally that HIV testing should be voluntary, done only with informed and free consent, with appropriate pre- and post-test counselling and with protection for the confidentiality of test results: UNAIDS/WHO Policy Statement on HIV Testing (June 2004).

\textsuperscript{1121} NGOs may carry out activities on the basis of the Law on public organizations [Закон Туркменистана об общественных объединениях], 21 October 2003.

\textsuperscript{1122} The program is approved by the Decision of the President of Turkmenistan "On the creation of the National Program on Counteracting Drug Trafficking and Assistance to Persons with Addiction to Narcotics and Psychotropic Substances for 2006-2010," Decision No. 7856 (24 April 2006). [Национальная программа по противодействию незаконному обороту наркотиков и оказанию помощи лицам, находящимся в зависимости от наркотических средств и психотропных веществ].
ministries and agencies responsible for implementing concrete measures in these areas. The Committee also initiates and facilitates epidemiological and statistical studies related to the drug situation in Turkmenistan.

The National Programme against drugs is funded from the state budget. International organisations, following agreements with Turkmen government provide financial and technical support in implementation of national plans and programmes.

The programme includes:

- activities aimed at legislation development;
- activities to counter illegal drug trafficking;
- activities to control legal circulation of narcotics, psychotropic substances and precursors;
- activities to provide medical and social care for persons dependent to narcotics and psychotropic substances; and
- international cooperation.

The programme does not include reference to any harm reduction measures, such as programmes of opioid substitution therapy (OST) or needle and syringe programmes (NSP). Rather, its components are focused only on reducing drug supply (through law enforcement measures) and reducing drug demand. With respect to demand reduction, the programme includes drug use prevention measures such as educational activities for the population as a whole, as well as activities targeting youth. The programme includes a plan to establish a hospital for the compulsory treatment of women with drug dependence. In addition, the National Programme provides for compulsory drug testing of workers in the workplace as an ostensible prevention measure.\footnote{Para. 34 of the National Program on Counteraction to Drug Trafficking for 2006-2010 calls for drug testing of workers in the workplace.}

Along with these measures, the government plans to conduct annual epidemiological surveys of HIV prevalence among people who inject drugs, and to open new medical and rehabilitation centres and telephone hotlines in the remote districts and in cities where narcotic use is deemed to be extensive enough to warrant such services. Representatives of civil society were not involved in the development of the National Programme, but quasi-governmental public organizations are involved in a number of the programme’s activities.
3. CRIMINAL AND ADMINISTRATIVE LAW PROVISIONS

Law on narcotics
According to the Law on narcotic drugs, psychotropic substances, precursors and measures to counter their illegal circulation (hereinafter “Law on narcotics”), the substances which are subject to control in Turkmenistan are those on a list approved by the President. The following categories have been established through such lists, with varying control measures applied by the state:

- narcotics and psychotropic substances whose distribution is forbidden;
- substances used as medical preparations for which distribution is limited, subject to specific control measures;
- substances used as medical preparations for which distribution is limited, subject to lesser means of control;
- multi-component medical products that contain narcotics, psychotropic substances or precursors, but which are not subject to control;
- precursors whose distribution is limited, subject to specific control measures; and
- narcotics and psychotropic substances which have been found in illegal circulation in small, large and extra large quantities. (Schedules set out what constitute “small”, “large” and “extra large” quantities of various prohibited drugs.)

The Law on narcotics forbids consumption of narcotics and psychotropic substances without a physician’s prescription, but there is no administrative or criminal liability or punishment under Turkmen law for the use of narcotics per se. However, there is administrative liability for possession of very small quantities of drugs not for sale. Similarly, the Law on narcotics does not create liability simply for possessing drug use equipment (e.g., syringes, disinfectants, utensils, etc.), but it does provides for confiscation of tools and equipment used for illegal manufacturing and consumption of narcotics.

However, the Law on narcotics (on detecting persons illegally consuming narcotics and psychotropic substances) states that if there is information that a person uses drugs illegally, or if there is a “founded suspicion” that a person is under the influence of drugs, he/she should be tested. Illegal drug use may also be confirmed by statements from witnesses. Such provisions contribute to an environment in which people who use drugs go (further) underground and create barriers to their access to health services, including drug dependence treatment, and other support services for social re-integration.

The Law on narcotics also forbids “propagation of narcotics”. This includes a prohibition on any activity directed at public dissemination of ideas regarding the development, processing, application or use of narcotics (including producing or distributing books or mass media containing such ideas), as well as a prohibition on “promoting the use in medical practice of medical products containing narcotics” that aims to suppress a patient’s or negatively affect mental and physical health. Nothing in the law of Turkmenistan clearly exempts harm reduction measures from the possible scope of this prohibition, leaving it open to possible misinterpretation that could interfere with informing the population about opioid substitution treatment (OST) programmes or discussing the benefits of OST or other programmes that help prevent HIV infection or other harms associated with unsafe drug use. The national expert team has recommended that the government make it clear that such programmes do not contravene this law on “propagation”; this could be done by way of legislative amendment or other perhaps through other means (e.g., in an official policy document, decree or order accompanying the implementation of such programmes). This would facilitate the functioning of such programmes, including by reducing the risk

1124 The current list was adopted by Presidential Decree “On approved of lists of drugs, psychotropic substances and precursors”, No. 9192 (13 November 2007).
1125 Law on narcotic drugs, psychotropic substances, precursors and measures to counter their illegal circulation, 9 October 2004, Article 2. (О наркотических средствах, психотропных веществах, прекурсорах и мерах противодействия их незаконному обороту) (Law on narcotics). See appendix for table with amounts in different categories under Turkmen law.
1126 Law on narcotics, Article 49.
1127 Law on narcotics, Article 45.
1128 Law on narcotics, Article 50.
1129 Law on narcotics, Article 47.
of those working in such programmes being accused of breaching the law.

**Administrative offences**

Under the *Code of Turkmenistan on Administrative Offences* ("Administrative Offences Code"), the following offences connected with narcotics attract administrative liability:

- **Illegal acquisition or possession of narcotics in small quantities without an intention to sell** is an administrative offence. The penalty is a fine or administrative arrest for up to fifteen days. Someone who has voluntarily handed over the small quantities of narcotic which were acquired or possessed, without an intention to sell, is released from administrative liability.

- The **failure to undertake measures to secure cannabis and opium poppy crops**, and the places where such crops are stored or processed, against theft is an administrative offence, as is the failure to take measures to destroy remains of such crops after cultivation and the production wastes containing narcotic substances. The penalty is a fine to be imposed on officials.

- **Illegal cultivation of opium poppy or cannabis** can lead to a warning or fine (other than in the case of types of poppy and cannabis whose cultivation is prohibited and which cultivation attracts more severe penalties under the *Criminal Code* – see below).

**Criminal offences**

Under Turkmenistan’s *Criminal Code*, the following offences connected with narcotics attract criminal liability:

- **Illegally acquiring or possessing narcotics or psychotropic substances in a small quantity, without an intention to sell, when committed for the second time within a year after administrative charges were imposed for the same conduct**, is punishable with a fine, corrective works for up to two years or imprisonment for up to two years.

- **Illegally manufacturing, processing, acquiring, possessing, transporting or transferring a narcotic or psychotropic substance, without an intention to sell**, is punishable by imprisonment for a term of up to five years. The same offence committed for the second time or by an organized group leads to imprisonment from three to 10 years.

- **Illegally manufacturing, processing, acquiring, possessing, transporting, or transferring narcotics or psychotropic substances, with an intention to sell**, is punishable by imprisonment for three to ten years, with or without confiscation of property.

- **Illegally cultivating prohibited plants containing narcotic substances** is punishable by corrective works for up to two years or imprisonment for up to three years.

- "Inducing consumption" of narcotics or psychotropic substances is punishable with imprisonment for up to five years and/or compulsory residence in a certain district for a term of two to five years. Inducement is understood as any deliberate actions directed at other persons to create a desire to consume (e.g., persuading, offering, advising, etc.).

---

1130 Code of Turkmenistan on Administrative Offences (Кодекс Туркменистана об административных правонарушениях), Law No. 35 (17 December 1984, last amended in 2002). According to the Code (Article 14), administrative liability can be imposed as of 16 years of age.

1131 Administrative Offences Code, Article 43(1).

1132 Administrative Offences Code, Article 102-1.

1133 Administrative Offences Code, Article 102-2.

1134 Criminal Code of Turkmenistan, Law No. 222-1 (12 June 1997).

1135 Criminal Code, Article 298.

1136 Criminal Code, Article 293.

1137 Criminal Code, Article 292.

1138 Criminal Code, Article 295.

1139 Criminal Code, Article 296. There is nothing that clearly acknowledges that measures aimed at reducing harms associated with drug use are exempt from this provision.
- Organizing the consumption of narcotics or psychotropic substances in family celebrations, festivals, demonstrations or other mass actions is punishable by a fine or imprisonment for up to five years.\textsuperscript{1140}

- Organizing or maintaining sites for the consumption of narcotics or psychotropic substances is punishable with imprisonment for a term of three to eight years, and may also include compulsory residence in a certain district for a term of two to five years.\textsuperscript{1141} Granting the use of premises for the consumption of narcotics or psychotropic substances is punishable by imprisonment for up to three years and/or obligatory residence in certain district for a term of two to five years.\textsuperscript{1142}

Usually, criminal liability only arises for those aged 16 or older. However, for some crimes, the minimum age of liability is 14 years — this includes the offences of illegally manufacturing, processing, acquiring, possessing, transporting, and transferring of narcotics or psychotropic substances with an intention to sell, and the offences of theft or extortion of narcotics or psychotropic substances. For repeat offences involving the trafficking of narcotic or psychotropic substances, the severity of the sentence can be increased. For “serious” and “especially serious” crimes, the court can add the additional penalty of confiscating property. The person who has committed a crime while intoxicated by alcohol, a narcotic or other stupefying substance, is still subject to criminal liability. The degree of intoxication and its influence on the person in committing the crime are taken into account when deciding on the punishment.\textsuperscript{1143}

**Compulsory drug testing, including by law enforcement**

Under Turkmen law, a person is subjected to non-voluntary drug testing if either

- an authorized state body received official information as to his or her illegal consumption of narcotics, or
- there is a “proven suspicion” [обоснованные подозрения] that she or he is intoxicated by narcotics.

The fact of illegal consumption of narcotics can be confirmed by evidence from witnesses, detectable signs of narcotic intoxication, the results of a physical examination and/or tests for the presence of a narcotic or psychotropic substance in the patient’s bloodstream.\textsuperscript{1144} If a person refuses to undergo drug testing, she or he can be forcibly delivered to a narcological establishment for testing. The law allows compulsory drug testing based simply on suspected drug use, even though drug use is not a punishable act under the law; this raises human rights concerns such as infringing liberty, security of the person, and privacy, and if the results of compulsory drug testing are used in any sort of criminal or administrative proceeding against the person tested, this would also infringe the right against self-incrimination.\textsuperscript{1145}

In addition, the Administrative Offences Code provides that a vehicle driver for whom there are “sufficient grounds” [достаточные основания] to believe that he or she is intoxicated may be temporarily deemed unfit to drive and subject to compulsory drug testing.\textsuperscript{1146}

Finally, the Criminal Procedural Code provides that in an investigation of criminal charges related to the illegal trafficking of narcotics, the investigator, if necessary, may require a “judicial-narcological examination” to identify the presence of a narcotic addiction in a person under investigation.\textsuperscript{1147}

**Groups at high risk of HIV: criminal and administrative law issues**

Some other provisions of Turkmenistan’s administrative and criminal legislation raise human rights concerns and create barriers to HIV and STI prevention and treatment among those who are vulnerable, by

\textsuperscript{1140} Criminal Code, Article 301.
\textsuperscript{1141} Criminal Code, Article 297.
\textsuperscript{1142} Criminal Code, Article 297(3).
\textsuperscript{1143} Criminal Code, Article 25. In the case of offences other than those for which intoxication is an inherent part of the offence (e.g., driving while intoxicated), to treat intoxication per se as an aggravating factor when sentencing arguably amounts to discrimination on the basis of health status (i.e., drug or alcohol dependence) in at least some cases, as it would amount to imposing a harsher penalty on the person convicted just because of this condition.
\textsuperscript{1144} Law on narcotics, Article 50.
\textsuperscript{1145} International Covenant on Civil and Political Rights, 999 U.N.T.S. 171 (1966), Articles 7, 9, 14, 17 (“ICCPR”).
\textsuperscript{1146} Administrative Offences Code, Article 257.
\textsuperscript{1147} Criminal Procedural Code, Articles 72-75.
further penalizing and marginalizing those who are often already stigmatized and reluctant to seek out health services or other services.

Compulsory testing and treatment
For example, if a person is informed by public health services that he or she has STI, and evades treatment, he or she can be held administratively liable and punished by a fine.\footnote{1148 Code of Administrative Offences, Article 44.} In effect, this amounts to obligatory treatment for STIs, contrary to the accepted norms that testing and medical treatment should be voluntary, based on informed consent, including out of respect for human rights.\footnote{1149 UNAIDS/WHO Policy Statement on HIV Testing (June 2004).} A person who has been identified as a contact (e.g., past sexual partner) of a person with a diagnosed STI is also administratively liable if he or she evades treatment; again, the offence is punishable by a fine.\footnote{1150 Code of Administrative Offences, Article 45.}

Compelling disclosure of contacts
It is an administrative offence, punishable by a fine, for a person with a STI to conceal from public health authorities the source of his or her infection and the names of his or her sexual contacts.\footnote{1151 Code of Administrative Offences, Article 46.} “Malicious evasion” from treatment for “venereal disease” — that is, avoiding treatment after a warning issued by a public health body — is a criminal offence punishable by a fine or corrective works for up to one year.\footnote{1152 Criminal Code, Article 118.} It is difficult to see how this could be effectively enforced in any verifiable way, and according to UNODC is not currently used in practice.

Criminalizing STI and HIV transmission or exposure
Knowingly transmitting an STI is a criminal offence punishable by a fine or corrective works or imprisonment for up to two years.\footnote{1153 Criminal Code, Article 117.} The national expert group was of the view that these provisions are not effective because STI testing and treatment is done for a fee and consequently, the law enforcement bodies have to make efforts to force the suspect to pay expenses for tests and treatment of STIs. The Criminal Code also has a provision specifically on “Transmission of the AIDS disease”. It states that “knowing exposure to AIDS” of another person is an offence punishable by up to three years in prison; in cases of actual transmission, the penalty is up to five years’ imprisonment.\footnote{1154 Criminal Code, Article 119.} HIV transmission in relation to two or more persons or a minor carries a penalty of up to eight years’ imprisonment. HIV transmission as a result of medical negligence carries a penalty of up to five years’ imprisonment and suspension of the right to practice in the person’s profession for up to three years. UNAIDS has recommended against such overbroad use of the criminal law to deal with HIV transmission or exposure.\footnote{1155 UNAIDS, Policy Brief: Criminalization of HIV transmission (August 2008).}

Criminalizing men who have sex with men
Homosexuality remains illegal in Turkmenistan, punishable by imprisonment for up to two years, with or without an obligation to reside in a certain area for the period from two to five years.\footnote{1156 Criminal Code, Article 135.} This discrimination contravenes international human rights law, including rights to non-discrimination and privacy, and is counter-productive in that it undermines HIV prevention efforts and access to health information and services among men who have sex with men.\footnote{1157 UNAIDS/OHCHR, International Guidelines on HIV/AIDS and Human Rights (2006 Consolidated Version), paras. 123-124; UNAIDS, Policy Brief: HIV and Sex Between Men (August 2006).} The UN Human Rights Committee has ruled that the right to privacy under the International Covenant on Civil and Political Rights (Article 17) is violated by such laws criminalizing consensual sex between adults of the same sex. The Committee has specifically noted that:

...the criminalization of homosexual practices cannot be considered a reasonable means or proportionate measure to achieve the aim of preventing the spread of HIV/AIDS... [B]y driving underground many of the people at risk of infection ....[it] would appear to run counter to the implementation of effective education programmes in respect of the HIV/AIDS prevention.\footnote{1158 UN Human Rights Committee, Nicholas Toonen v. Australia, Communication No. 488/1992, UN Doc. CCPR/C/50/D/488/1992 (31 March 1994), para. 8.5.}
Criminalizing sex work and sex workers

Sex work, sex workers and their associates are penalized, which impedes effective HIV prevention and other health protection and promotion efforts for this vulnerable population and runs contrary to international recommendations.1159 Both prostitution and inducing someone, for a profit, into having sexual relations with a prostitute, are administrative offences punishable by a fine or administrative arrest for a term of up to fifteen days.1160 If a person is convicted of prostitution again within one year of a first administrative offence, this amounts to a criminal offence, punishable by a fine, corrective works for up to two years or imprisonment for up to two years.1161 Organizing or maintaining brothels for debauchery or prostitution are crimes punishable by imprisonment for up to five years with or without confiscation of property and with or without obligatory residence in a certain district for two to five years).1162 Procuring a prostitute’s sexual services for someone is a crime punishable by imprisonment for up to five years and/or confiscation of property;1163 pimping someone engaged in prostitution is a crime punishable with imprisonment for a term of two to six years and/or confiscation of property.1164 Subsequent offences attract a stricter punishment (imprisonment for a term of three to eight years).

1160 Administrative Offences Code, Articles 176(1) and 176(2).
1161 Criminal Code, Article 138.
1162 Criminal Code, Article 140.
1163 Criminal Code, Article 141 (сводничество).
1164 Criminal Code, Article 142.
4. HEALTH SERVICES

The Constitution of Turkmenistan\textsuperscript{1165}, the Law on health protection,\textsuperscript{1166} the Law on refugees\textsuperscript{1167}, the Law on migration,\textsuperscript{1168} the Law on the legal status of foreign citizens,\textsuperscript{1169} the Law on prevention of HIV\textsuperscript{1170} and the Law on narcotics all provide various aspects of a right to health protection, including free use of the network of official public health bodies by citizens, foreign citizens, persons without citizenship and refugees. Access to primary and emergency health care is provided based on the individual’s place of residence. For those who are unemployed or without a specific residence, provision of free health services is carried out in accordance with the general practice in the place where the application was made. Legally, migrants and refugees have access to treatment equal to that of citizens of Turkmenistan.

Free use of the network of official public health services provides: emergency medical aid; medical services to those sick with tuberculosis or mental, oncological or infectious diseases; services for those with drug dependence; and services for pregnant women and children under the age of 16. For people with HIV or AIDS and people who use drugs, treatment of these diseases and accompanying hepatitis treatment is carried out on a free basis. In the case of paid health care services, the health insurance policy provides for 50% coverage of the cost of treatment and 90% of the cost of medical products (e.g., prescribed medicines).

According to the national expert group, the use of narcotic drugs or psychotropic substances is not an acceptable reason to deny someone treatment for hepatitis, tuberculosis, HIV or drug dependence. Partnerships exist between the medical institutions providing treatment of drug dependence, tuberculosis and hepatitis C infection. At the time of the national expert group’s report, there were no people receiving ARV treatment in Turkmenistan.

4A. DRUG DEPENDENCE TREATMENT

Treatment of those with alcoholism or dependence on drugs or inhalants is considered part of psychiatric assistance services set out by law, which includes mental health examinations and the diagnosis of psychiatric disorders, along with treatment, care and medical and social rehabilitation.\textsuperscript{1171} According to the national expert group, narcological centres providing “anonymous” treatment operate in the capital city Ashgabat and in every province. In all, the country has eight such treatment sites, providing services to both men and women. In addition, in Ashgabat and all provinces, there are also women-only sections in hospitals for treatment of narcotic addiction. According to the national expert group, during nine months of 2007, drug dependence treatment was supplied to 17,741 patients, including 1493 women.\textsuperscript{1172} There were 1995 people registered as having narcotic addiction who also had diagnosed hepatitis. In total, there were 32,969 people on narcological registry of Turkmenistan at the time of the national expert group’s report.

In addition to the substantive provisions related to drug dependence treatment in the Law on psychiatric assistance, the Law on narcotics, and the Law on health protection, standards for drug dependence treatment are provided in an interdepartmental order of the Ministry of Health and Medical Industry.\textsuperscript{1173} The state guarantees provision of free drug dependence treatment and medical and social rehabilitation to persons with narcotics addiction. The treatment of drug dependence can include medication-assisted detoxification, outpatient treatment and rehabilitation activities. Theoretically narcological assistance could

\begin{itemize}
  \item \textsuperscript{1165} Constitutions of Turkmenistan, (26 September 2008), Article 35.
  \item \textsuperscript{1166} Law of Turkmenistan on health protection, [Об охране здоровья граждан], No. 157-II, 14 December 2002.
  \item \textsuperscript{1167} Law of Turkmenistan on refugees, [О беженцах] No. 231-I, 12 June 1997.
  \item \textsuperscript{1168} Law of Turkmenistan on migration, [О миграции] No.30-III, 7 December 2005.
  \item \textsuperscript{1169} Law of Turkmenistan on the legal status of foreign citizens, [О правовом положении иностранных граждан], No. 901-XII, 8 October 1993.
  \item \textsuperscript{1170} Law of Turkmenistan “On prevention of the disease caused by the human immunodeficiency virus (HIV)” [О профилактике заболевания, вызываемого вирусом иммунодефицита человека (ВИЧ-инфекция)], No. 78-II, 7 July 2001.
  \item \textsuperscript{1171} Law on psychiatric assistance [О психиатрической помощи], No. 869-XII (1 October 1993), Article 1.
  \item \textsuperscript{1172} Information provided by national expert group for September 2007.
  \item \textsuperscript{1173} Ministry of Health and Medical Industry, Order No. 300 (14 October 2000).
\end{itemize}
be provided by both private and public health care facilities. At present treatment of drug dependence is conducted on the base of public health care facilities only.

As a general matter, the medical confidentiality of persons who have voluntarily sought drug dependence treatment from narcological institutions is to be protected. However, data on a person receiving treatment can be disclosed to law enforcement bodies in the event of an official inquiry by such bodies; in addition, health care workers are obliged to transfer data on those identified as drug users to local narcological experts and to report cases of suspected overdose. According to the information provided by the national expert group, naloxone, an opioid antagonist used for emergency treatment of overdoses, is considered a poisonous medical product subject to control. Naloxone is not registered in Turkmenistan and is not used for medical purposes.

Compulsory drug dependence treatment

Ordinarily, medical interventions, including drug dependence treatment, are provided upon a person’s voluntary application or with his or her consent (or, in the case of minors, consent by parents or lawful representative). However, according to the Law on health protection, medical intervention without consent is allowed in the cases of:

- persons “suffering from diseases representing a danger to other people”;
- persons “suffering from grave mental disorders”; and
- persons who have committed “socially dangerous acts” or who are suspected of those.

According to this law, the list of diseases representing a danger to other people, and the list of institutions of public health services for medical aid to treat patients with various diseases, is approved by the Cabinet of Ministers of Turkmenistan. As of December 2008, the list of especially dangerous infectious diseases included such diseases as plague, cholera, hemorrhagic fevers and HIV.

In addition, under the Law on narcotics, a court may impose involuntary medical interventions on anyone diagnosed with "narcotic addiction", if he or she evades medical supervision and treatment and continues to use drugs. Bodies from either law enforcement or the public health services may seek such a court order. According to the law, in the case of a minor at least 16 years of age or older who evades compulsory drug dependence treatment or who continues to use drugs after such treatment, a court may order the minor to be detained in a special medical and educational facility of the public health services for a term of six months to two years. According to the information provided by UNODC, no such facilities for minors currently exist. In practice minors undergo treatment in a regular unit in a narcological facility, or if convicted with criminal offence - in correctional institution.

Persons convicted of a criminal offence are subject to compulsory drug dependence treatment in prison, and after release, if treatment needs to be continued, in medical institutions in accordance with the general practice (see further details below).

As is evident from the legislative provisions just described, compulsory medical interventions can regularly be applied to persons who use drugs. International organizations underline the principle that drug...
dependence treatment should generally be voluntary. As a general proposition, compulsory medical treatment violates human rights, including to liberty, security of the person and privacy, and should be applied only in extreme, clearly defined cases with a view to preventing a person from causing imminent, serious harm to himself or herself or to others.

**Substitution therapy**

Opioid substitution treatment (OST) is a well-studied, effective method of managing and treating opioid addiction used widely in many jurisdictions, and is recognized as a key element of HIV prevention among people who inject drugs. International drug control treaties ratified by Turkmenistan do not prevent the use of medications such as methadone and buprenorphine as OST, and they are recognized by the World Health Organization as “essential medicines.”

OST programmes do not exist in Turkmenistan, but some legislative provisions allow for its introduction. For example, methadone is included on the list of narcotics and psychotropic substances for which limited distribution, as a medical preparation, is permitted, subject to certain controls. Therefore, methadone can be used for medical purposes on the basis of a prescription made on special forms. Prescription of narcotics and psychotropic substance (which would include medications used for OST) by medical workers of private health care facilities is forbidden.

**Registration of people who use drugs**

Persons with drug dependence are subject to a system of extensive registration by the state, being registered with both law enforcement bodies and treatment-and-prevention institutions of the state system of public health services. Data in such registries is maintained by the narcological service of the Ministry of Health and Medical Industry, and by local police forces under the Ministry of Internal Affairs.

Inclusion in the narcological database can temporarily preclude a person from being eligible for some kinds of employment and activities seen as higher risk. That decision is made by a medical commission; it may be appealed through a judicial procedure. Registration as a person who uses drugs can also entail a number of other restrictions of the rights, such as:

- denial of a driving license;
- restriction on parental rights or eligibility to adopt — according to the Code on Marriage and Family, one or both parents can be deprived of parental rights on the basis of chronic alcoholism or drug dependence; and
- denial of the right to vote, if the person using drugs has been deprived of legal capacity in a judicial procedure — which the court may do if the person, as a result of drug use, puts his or her family in a grave financial situation.

The Law on migration establishes that drug dependence, is a basis for denying a visa or residence permit to a foreign citizen or person without citizenship. These are also grounds on which a residence permit may be cancelled.

---

1187 President of Turkmenistan, “On approval of lists of narcotics, psychotropic substances and precursors,” Decision No. 9192 (13 November 2007), Appendix No.2.
1188 Law on narcotics, Article 33 ("Release of narcotics and psychotropic substances to individuals for medical purposes").
1189 Ministry of Health and Medical Industry of Turkmenistan, Order No. 300 of 14 October 2000.
1190 Law on narcotics, Article 53.
1191 Code on Marriage and Family, Articles 70 and 115.
1192 Law on narcotics, Article 53; Civil Code of Turkmenistan, Articles 26(1) and 27(1).
1193 Law of Turkmenistan on migration, Article 15.
HIV prevention education
The HIV prevention service of Turkmenistan consists of six centres: the National Centre in Ashgabat and five provincial centres of HIV prevention, which provide counselling and testing for HIV and telephone hotlines. Currently, measures of HIV prevention in Turkmenistan consists of information and education activities among youth and the general population, and the distribution of condoms by official bodies and public organizations. Information about HIV is included into school curricula, and is available at women's counselling agencies and family and children's centres. These are no systematic evidence based measures of HIV prevention specifically tailored to people who inject drugs and prisoners in Turkmenistan.

HIV testing
The Law on prevention of HIV provides the right of citizens of Turkmenistan, foreigners and stateless persons living in the state's territory to have access to "voluntary, confidential, anonymous HIV testing." All persons getting tested for HIV are to receive pre- and post-test counselling. The legislation does not explicitly require informed consent to HIV testing. Under the Law on migration, citizens of Turkmenistan, foreigners and stateless persons are subject to mandatory HIV testing in the presence of "epidemiological indications". Foreigners and stateless persons who test HIV-positive are denied a visa or residence permit on this basis, and are subject to having a residence permit cancelled and to administrative deportation from Turkmenistan. (STIs and drug dependence are other grounds for denial of a visa or residence permit).

A regular medical examination, including HIV testing, is also done for medical personnel who carry out diagnostic tests for HIV, provide medical care and preventive interventions to persons with HIV and AIDS, or have contacts with blood and other materials from infected persons.

According to international standards, an HIV test should be done on a voluntary basis only; mandatory testing is justified only for donors of blood, organs or tissues.

Treatment for people living with HIV
The treatment of HIV infection without the consent of the patient or his or her lawful representatives is allowed on the basis of the Law on health protection of citizens, which establishes that treatment may be imposed on persons suffering from "diseases representing a danger to others" (which has been defined to include HIV) or "suffering grave mental disorders", and on persons who have committed socially dangerous acts.

1194 Law on prevention of HIV, Article 5. The wording of the article states simultaneously that testing is "anonymous" and "confidential"; whether there is access to any testing that is entirely anonymous remains unclear.
1195 Instruction of the Ministry of Health and Medical Industry, "On Physical Examination on HIV-infection and detection of HIV-infected and those sick with AIDS in Turkmenistan" (14 January 2004), para. 5.
1196 Law on prevention of HIV, Article 6.
1197 Law on migration, Article 18: a foreign citizen is subject to administrative deportation in cases where it is required to protect the health and or morals of the population, or to protect the rights and legitimate interests of citizens of Turkmenistan and others.
1198 Law on migration, Articles 15, 16 and 18; and Government Resolution. No. 5833 "Status of foreign citizens and stateless persons on the territory of Turkmenistan" (Положение иностранных граждан и лиц без гражданства на территории Туркменистана), 2002.
1199 Information presented by the expert group of Turkmenistan.
1200 Law on prevention of HIV, Article 11.
1202 Law on health protection of citizens, Article 28(1). For the list of especially dangerous infectious diseases (including plague, cholera, hemorrhagic fevers and HIV), see: Ministry of Health and Medical Industry, "On sanitary protection of the territory of Turkmenistan," Order No.116 of 26 December 1995, prepared on the basis of Order No. 18 of the Vice-Chairman of the Cabinet of Ministers of Turkmenistan of 12 December 1995.
According to the *Law on prevention of HIV*, people with HIV receiving outpatient treatment are entitled to free medications, including antiretroviral (ARV) therapies. However, as of this writing in December 2008, ARV therapy is not available in Turkmenistan. ARV medicines are not included in the List of Essential medicines in Turkmenistan. Theoretically people living with HIV and AIDS are eligible to receive reimbursement for costs connected with travel to and from the place of treatment from the local institution of the public health services. Parents (or other lawful substitute) whose children under 14 live with HIV, or are sick with AIDS, have the right to a joint stay with them in a hospital while receiving the temporary disability allowance. One of the parents (or other lawful substitute), who takes care of a child under 16 recognized as being disabled on the basis of HIV or AIDS has the right to have the period of care included in the pension record. Persons with HIV or AIDS under the age of 16 have the right to a monthly allowance. In 2007 the Ministry of Health of Turkmenistan approved the new standards of medical care of patients with tuberculosis, that include standards on conducting counselling and treatment of patients with tuberculosis and HIV. Protocols for the prevention of vertical transmission of HIV and HIV post-contact prevention have been developed, and are presently (April 2009) in the process of approval.

**Patients’ rights, including confidentiality**

The right of the patient to health protection is guaranteed by the state, and includes, *inter alia*: respect-ful and humane treatment from health workers; mitigation of pain caused by disease; confidentiality of information on the patient’s application for medical aid, state of health, diagnosis and other data from examination and treatment; and voluntary consent or refusal from medical intervention. The law states that persons with mental disorders keep all rights and freedoms of citizens. Information on the fact of applying for medical aid, a patient’s state of health, the diagnosis of disease and other data received during examination and treatment, constitute “medical secrets” protected by law. Breaching a patient’s confidentiality by disclosing medical or other personal information, including information related to HIV status, can attract criminal liability. In addition, the *Law on prevention of HIV* specifically protects the privacy of people living with HIV by imposing a legal obligation on workers of institutions of the public health services to keep information on patients’ HIV status confidential.

Disclosure of confidential health information without the consent of the patient (or his or her lawful representative) is allowed in the following circumstances:

- in order to examine and treat a person who is not capable, because of his or her health condition, of expressing his or her will;
- in case of risk of distribution of infectious diseases, mass poisonings and injuries;
- upon receipt of a written demand from bodies of inquiry or investigation, the Office of the Public Prosecutor or a court, in connection with an investigation or court proceeding;
- to the parents or lawful representatives in the case of providing medical aid to a minor under the age of 16; and
- in circumstances where there are sufficient grounds to believe that illegal acts have caused harm to the health of others.

A report on the results of HIV blood tests is provided quarterly to the Ministry of Health and Medical Industry and to the State Committee of Turkmenistan on Statistics. Confidentiality of the information is ensured by the employees of the HIV prevention centres under the Ministry of Health. The access rights to such data are provided to heads of the HIV prevention centres, heads of laboratories, departments of epidemiology within the Ministry of Health.

A patient (or his or her lawful representative) can file a complaint about an infringement of rights directly to the official of the health care facility where medical aid is provided, to a higher body or to a court.

---

1204 Information provided by national expert group.
1205 *Law on health protection*, Article 25.
1206 *Law on psychiatric assistance*, Article 5.
1207 *Law on prevention of HIV*, Article 9; *Law on health protection*, Article 60.
1208 Criminal Code, Article 114.
1209 *Law on prevention of HIV*, Article 9.
1210 *Law on health protection*, Article 60.
1211 *Law on health protection*, Article 25(3).
5. PRISONS

In Turkmenistan, the Ministry of Internal Affairs has jurisdiction over correctional institutions. In total, the country has 17 such institutions: one prison; one “general security”, three “strict security” colonies, one “special security” colony and one settlement-type colony (operated at a less strict security level than other colonies), all of which house adult men only; one colony for women (encompassing all different levels of security); one colony for minors; one colony specifically for former law enforcement personnel; one colony for medical treatment of male prisoners; five pre-trial detention centres; one medical-labour facility (for compulsory treatment of alcohol and drug dependence).1212

The national expert group reports that persons sentenced for narcotics-related crimes of “medium seriousness” usually serve time in general security colonies. According to figures from national expert group, as of 2007, 19% of prisoners in Turkmenistan’s penitentiary system were serving sentences for drug-related offences.1213 The national expert group states that there are no narcotics in any of the penitentiary institutions.

According to the Corrective Labour Code, food, clothes, and necessary items for personal hygiene are provided free of charge.1214 Those prisoners who work are charged for expenses related to their maintenance in prison. Prisoners have the right to buy food and basic personal necessities using credit earned through prison work. Prisoners with disabilities of the “first category” and “second category” (i.e., conditions with serious impairments), and those released from work based on sick leave, as well as pregnant women, nursing mothers and minors, can get food and basic personal necessities using money received as transfers from family and friends outside of prisons.

Health care in the correctional system
According to the statistical data provided by the national expert group, no cases of HIV or hepatitis C were registered in any institution of the penitentiary system, but 719 convicts had diagnosed tuberculosis (2006 data).

Total documented cases of diagnosed narcotic addiction, tuberculosis and mental disorder in Turkmen correctional institutions1215

<table>
<thead>
<tr>
<th></th>
<th>2005</th>
<th>2006</th>
</tr>
</thead>
<tbody>
<tr>
<td>Narcotic dependence</td>
<td>3318</td>
<td>2999</td>
</tr>
<tr>
<td>Tuberculosis</td>
<td>876</td>
<td>719</td>
</tr>
<tr>
<td>Mental disorders</td>
<td>31</td>
<td>28</td>
</tr>
</tbody>
</table>

The Medical Service of the Penitentiary Department within the Ministry of Internal Affairs is responsible for medical services in the institutions of the penitentiary system and pre-trial facilities, based on needs identified and submitted by correctional facilities and pre-trial facilities.1216 The national authorities state that no complaints have ever been received from prisoners regarding the supply of medical accessories or medicines.

According to the Law on health protection, prisoners and people in pre-trial detention have the right to health care, including in the public health care facilities, and pregnant women have the right to pre-natal and natal care.1217

1212 Information reported by the national expert group from Turkmenistan. This closed residential facility for compulsory treatment of alcohol and drug dependent persons and their re-education through mandatory labour (for non-offenders) exists under the Ministry of the Interior. Joint Decree of the Ministry of Health and Medical Industry and the Ministry of Internal Affairs “On detection, registration and enforcement of forced measures to persons suffering from drugs and psychoactive substances dependence”, No.163/134 (30.08.2006).
1213 According to the national expert group, this 19% figure breaks down as follows: 3.12% in general security colonies; 9.41% in strict security colonies; 2.27% in the one special security colony; and 4.2% in the one prison.
1214 Corrective Labour Code of Turkmenistan [Исправительно-трудовой кодекс], 1971, Article 74.
1215 Data shown in this table was provided by the national expert group.
1216 Ministry of Internal Affairs, Order “On medical care for persons contained in investigative insulators, correctional facilities and hospital of the Penitentiary within the Ministry of Internal Affairs of Turkmenistan” (17 July 2002).
1217 Law on health protection, Article 23.
HIV prevention and treatment

According to the national expert group, currently HIV prevention in prisons consists of compulsory HIV testing and some measures to provide education and information. The "National Programme on Prevention of HIV/AIDS/STDs in Turkmenistan for 2005-2010", noted above, provides for carrying out trainings for prisoners on HIV/STI prevention and development of high moral standards. Such initiatives are implemented by medical workers of the institutions and state organizations — for example, the AIDS Centre which periodically carries out educational session on HIV/AIDS for prisoners. According to the national expert group, over a 9-month period in 2007, 6 seminars for medical workers and 47 presentations on HIV/STI prevention were delivered to law-enforcement personnel and prisoners. In total, 67 hours have been spent for educational work on HIV, reaching about 24,000 people. As of this writing, there are no plans to involve NGOs in HIV prevention efforts with prisoners. The national expert group has observed that HIV testing which is not accompanied by pre-test and post-test counselling, and testing which is not provided on a voluntary basis, can lead to an opposite effect, and push people away from seeking medical services. The national experts therefore recommend that the government introduce real and effective measures of prevention of HIV in the penitentiary system, and to ensure that testing is done on a voluntary basis, with pre-test and post-test counselling.

Drug testing and treatment of drug dependence

Drug testing is compulsory for prisoners in Turkmenistan. Prisoners with drug dependence receive treatment in medical units of the correctional facilities. People with drug dependence who are serving a term for committing administrative offences receive treatment in a treatment and labour facility. Minors aged 16 or older who are drug-dependent and are evading treatment are subject to court-ordered compulsory treatment in medical-educational facilities for a term of six months to two years. The primary goal of the medical-educational facilities is treatment and re-education of those suffering from drug dependence. For these purposes, theoretically these institutions organize special treatment, in isolation, and general educational and vocations training.

Prisoners who are subject to compulsory drug dependence treatment are hospitalized for at least 60 days and then receive supportive treatment on an out-patient basis, in combination with "labour therapy". According to the national expert group, an “optimal” term of compulsory treatment in the system of penitentiary is two years. During the first year, prisoners with drug dependence are seen by psychiatrists and narcologists not less than once a month; during the second year, not less than once every two months. Supportive out-patient treatment is provided every 3 months for 3-4 weeks at a time. According to the law, if, by the time of release from imprisonment, the treatment is not finished, the administration of the correctional institution files a petition to a court, accompanied by a medical certificate, for an order to continue compulsory treatment of the person in a medical institution outside of prisons.

There are no programmes of rehabilitation for the pre-release and post-release period. Three months prior to a prisoner’s release, correctional institution personnel are required to notify the local police department responsible for the area to which the person will be directed upon release; that notice also indicates that employment and housing assistance needs to be provided to the person upon release.
6. DISCRIMINATION AND RESTRICTION OF RIGHTS

According to the Constitution of Turkmenistan, the state guarantees equality. The Criminal Code provides for criminal liability for direct or indirect infringement or restriction of rights and freedoms based on sex, race, nationality, language, origin, financial or official position, residence, religion, belief, or membership in public associations. Turkmen legislation does not currently include any specific provisions forbidding discrimination based on health status generally. However, the law prohibits an employer from unreasonably refusing to employ someone, or unreasonably dismissing someone from work, on the basis that he or she has HIV or AIDS.

Despite the general prohibition on discrimination in Turkmen law, there are a number of areas in which the law itself discriminates against people living with HIV or in other ways that affect efforts to address HIV among vulnerable populations (in particular, people who use drugs and prisoners). The following should be noted:

- **Employment restrictions against drug users**: People with drug dependence can be temporarily deemed ineligible to perform certain kinds of jobs and activities considered high risk — that is, work or activities connected with the operation and use of certain objects, equipment and substances where there is a greater risk of causing harm to people or the environment (e.g., pilots, drivers, railway personnel, and construction workers). This restriction can be imposed for up to three years, but may also include subsequent re-examination. The decision on imposing such restrictions is made by a medical commission. The decision to deem a person ineligible to perform certain kinds of jobs or activities can be appealed against in the court in an order established by the legislation. After a person is removed from the registry, this restriction is removed.

- **Discrimination in immigration and residence**: As noted above, according to the Law on migration, HIV infection, venereal diseases and narcotic addiction are bases for denying a foreigner a visa or residence permit in Turkmenistan, or for canceling a residence permit and deporting a non-citizen.

- **Denial of voting rights**: The right to participate in elections is denied to prisoners and to persons who are being held in custody as preventive punishment pursuant to an order under Turkmen law.

- **Restriction of family rights**: According to the Code of Marriage and Family of Turkmenistan, in cases of concern about child abuse or neglect, parents can be deprived of parental rights if they are “chronically dependent on alcohol or drugs”. This suggests that the health condition of alcoholism or drug dependence could be assumed to amount *per se* to a basis for depriving parents of their children.

According to principles well established in international human rights law, limitations or infringements on human rights may only be justified in accordance with clear standards. One key principle is that of non-discrimination, including based on health status. It will be the very rare case in which denying certain rights or benefits to entire classes of persons based on their health status (e.g., diagnosis with HIV infection or drug dependence) will be justifiable. Rather, discriminating in employment or denying parental rights should require case-by-case justifications, based on an assessment of individual circumstances, rather than based on inaccurate, generalized assumptions about a person’s capacity to perform the functions of a job or to be a suitable parent based on health status.

---

1222 Constitution of Turkmenistan, Article 19.
1223 Criminal Code, Article 145.
1224 Law on HIV, Article 10.
1225 The Cabinet of Ministers approves the "List of medical counter-indications for realization of some kinds of professional work and the activity connected with sources of high risk".
1226 Law on narcotics, Article 53.
1227 Law on migration, Article 15.
1228 Law on migration, Article 16.
1229 Law on elections of deputies of the Mejlis of Turkmenistan (25 October 2005); Law on elections of members of Gengeshes (25 October 2005); Law on elections of members of Etrap, City People’s Councils (25 October 2005); Law on elections of members of provincial councils (25 October 2005).
1230 Code on marriage and Family of Turkmenistan, 25 December 1969, Article 70.
7. CONCLUSIONS AND RECOMMENDATIONS

While Turkmenistan has programmes on HIV prevention, national legislation and policy includes numerous areas in which there is room for reforms to improve the law in order to pay more attention to the rights of people living with HIV or vulnerable to HIV (in particular prisoners and people who use drugs), thereby reducing their stigmatization and marginalization and their vulnerability to HIV and facilitating their access to medical services. Introducing such reforms is consistent with international human rights norms and will protect public health more broadly. The recommendations below are aimed at addressing issues identified by the national expert group of Turkmenistan and by the project’s technical advisors. Suggested language of legislative amendments is shown in shaded boxes.1

**National programmes and strategies**

**Recommendation 1: Ensure attention to and involvement of people living with HIV and vulnerable groups**

In the interests of being more inclusive, and hence better informed and more effective, national programmes and strategies on both HIV/AIDS and on drugs should explicitly guarantee:

- attention to HIV prevention, care, treatment and support for vulnerable groups, including people who use drugs and prisoners, among others;
- an explicit commitment to addressing discrimination against people living with HIV and members of vulnerable groups, and to respecting and protecting the confidentiality of people living with HIV;
- the involvement of and closer cooperation with civil society organizations, people living with HIV, people who use drugs, and members of other vulnerable groups in development and implementation of national programmes and strategies;
- better coordination of the activities of state and non-state stakeholders;
- in the case of the national programme against AIDS, better financing for the programme’s activities; and
- greater use of a large number of experts, with improved qualifications, on HIV/AIDS and related fields.

The involvement of civil society organizations, persons living with HIV and persons who use drugs in the work of bodies on HIV/AIDS could be strengthened by adding a specific legislative provision mandating this involvement in the **Law on prevention of HIV**.

**Recommendation 2: Ensure harm reduction measures are part of the response to HIV and to drugs**

The National Programmes addressing AIDS and drugs, as well as the **Law on HIV prevention**, omit any reference to harm reduction measures, yet these are critical to an effective response to HIV among people who use drugs. It is recommended to increase access to quality drug dependence treatment, and introduce such measures as opioid substitution treatment (OST), needle and syringe programmes (NSPs), and outreach programmes (including peer-to-peer programmes). In addition, the Government can strengthen its response to HIV by consulting more actively with civil society in discussing and studying the effectiveness and efficiency of such measures in the country as they are introduced.

---

1 In many instances, the wording of proposed legislative amendments is adapted from model provisions in Legislating for Health and Human Rights: Model Law on Drug Use and HIV/AIDS (Toronto: Canadian HIV/AIDS Legal Network, 2006), online in both English (www.aidslaw.ca/modellaw) and Russian (www.aidslaw.ca/modellaw-ru). This publication, consisting of a series of 8 modules on different issues, was used as a key reference by UNODC, national expert groups and the project’s technical advisors during the review and assessment of national legislation in the countries participating in the project. Where relevant, citations below are to specific modules of that resource; the accompanying text and commentary to be found in those modules may be useful to legislators and policy-makers in implementing these recommendations.
Administrative and criminal law issues

Recommendation 3: Remove criminal and administrative liability for possession of small quantities of drugs for personal consumption

Those who are most negatively affected by harsh criminal penalties for drugs, particularly criminal penalties for possessing drugs for personal use, are people with addictions. The national expert group has identified that local authorities are interested in humanizing the law in this area, particularly in the case of possession of small amounts of drugs without an intention to sell. The national expert group recommends the following:

- The Government should begin consultations with key persons with a view to identifying ways in which the law can be reformed in this area. Such consultation should include civil society organizations working in HIV prevention and otherwise providing health services to people who use drugs, as well as people who use drugs themselves to the extent feasible.

- The Government should investigate the experiences and approaches taken by other countries in tempering criminal or other liability for possession of drugs, such as introducing in law the concept of a small quantity for personal consumption, and providing alternatives to criminal liability and punishment for such possession (including encouraging treatment for drug dependence where warranted), as is allowed under international treaties.

In implementing reforms to remove criminal and administrative liability for possession of quantities for personal use, the Government should enact a provision such as the following in statutes such as the Law on narcotics, the Code of Administrative Offences and the Criminal Code (or even all three):

Decriminalization of possession without intention to sell

Notwithstanding anything in this or any other statute, the possession and use of a [small quantity] of a narcotic or psychotropic substance listed in [relevant schedule/list] for personal use does not constitute a criminal offence.

Recommendation 4: Remove prohibition of drug use from the law

Currently, drug use per se is prohibited according to the Law on drugs (however there is no penalty in Administrative or Criminal code). This has the effect of stigmatizing people who are dependent on drugs; creates barriers to seeking out health services, including treatment for drug dependence. A preferable approach, more consistent with human rights and with promoting and protecting health, would be to not punish people for a health condition, but to take measures to facilitate their voluntary access to health services that are respectful and humane. It is recommended to remove Article 49 prohibiting drug use from the Law on narcotics.

Recommendation 5: Provide alternatives to imprisonment for some drug offences

The national expert group has recognized that prisons are not well equipped to ensure appropriate HIV prevention and care, including for people who use drugs or to ensure drug dependence treatment for prisoners who need it. The national expert group has put forward a number of recommendations for improving the response to HIV and to drug dependence in the prison setting (see “Prisons” section below). However, the national expert group has also recognized that one important measure will also be to reduce the frequency with which people who use drugs go to prison. Implementing Recommendation 3 above is one important way to achieve this, by removing criminal liability at least in the case of possession of small quantities of drugs for personal use.

See Legislating for Health and Human Rights: Model Law on Drug Use and HIV/AIDS, Module 1: Criminal law issues, pp. 18-21. If the decision were made also to remove administrative liability for possession of small quantities for personal use, then this provision could be changed to refer to “depenalization” and could explicitly state that such possession also does not constitute an administrative offence. The provision could be added to the Administrative Offences Code as well.
In addition to taking such a step, to the extent that certain acts related to drugs remain criminal offences, at least the approach to punishing such crimes can be changed to reduce the use of imprisonment, with all the human and financial costs and harm to public health that imprisonment carries. The national expert group has recommended amendments to the Criminal Code to implement alternatives to imprisonment for non-violent offences related to drugs (without an intention to sell). Such alternatives are clearly permissible under international drug control treaties, which explicitly allow States Parties to those treaties to include, in their domestic legislation, alternatives to conviction and incarceration for drug offences. Creating alternatives to imprisonment could be achieved by enacting one or the other (but not both) of the following provisions:

**Alternatives to prosecution and imprisonment for certain drugs offences**

**Option 1: Referral to quasi-judicial commission**

1. The sections below apply to the following offences involving a narcotic or psychotropic substance when those offenses are committed in circumstances that do not involve violence and there is no accusation of an intent on the part of the accused person to sell said substance: i.e. those under Article 43 (1) of the Code of Turkmenistan on Administrative Offences and Articles 293 and 298 of the Turkmenistan's Criminal Code:
   - Illegal acquisition or possession of narcotics in small quantities without an intention to sell
   - Illegally acquiring or possessing narcotics or psychotropic substances in a small quantity, without an intention to sell, when committed for the second time within a year
   - Illegally manufacturing, processing, acquiring, possessing, transporting or transferring a narcotic or psychotropic substance, without an intention to sell

2. The offences referred to in section (1) shall be processed, and penalties applied if applicable and necessary, by a quasi-judicial commission (“the Commission”).

3. The Commission shall include a legal expert, as well as other experts such as medical practitioners, psychologists, social service workers or others with appropriate expertise in the field of drug dependence.

4. The rules of procedure governing the proceedings of the Commission, including the admissibility of medical evidence, shall be determined by the Ministry of Internal Affairs and the Ministry of Health and Medical Industry.

5. In arriving at the appropriate penalty for a person apprehended by police for the offences referred to in Section (1), the Commission shall consider:
   - the seriousness of the act;
   - the relative degree of fault;
   - the type of substance involved in the offence;
   - the public or private nature of the offence and, if relevant, the location of the offence;
   - the personal circumstances, namely economic and financial, of the offender; and
   - whether the offender is an occasional, habitual or dependent drug user.

6. The Commission may apply penalties including, but not limited to, one or more of the following:
   - a notice of caution;
   - a fine in proportion to the amount of the narcotic or psychotropic substance possessed for personal use, taking into account the economic situation of the alleged offender;
   - restriction on travel or attendance in certain places; and
   - suspension of driving or professional licences.

---

1234 Single Convention on Narcotic Drugs, 1961, UN, 520 UNTS 331, as amended by the 1972 Protocol, Article 36(2); Convention on Psychotropic Substances, 1971, UN, 1019 UNTS 175, Article 22; Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances, 1988, Article 3(4).

1235 Note that it will be important to avoid an order that prohibits the person from entering an area where important health services (e.g., needle and syringe programs, health clinics, etc.) are located.
(7) The penalties applied by the Commission shall not include custodial penalties.

(8) If the person apprehended for the offences referred to in Section (1) is found by the Commission to be dependent on a narcotic or psychotropic substance, the Commission may order that the person attend a specified number of meetings with the provider of a drug dependence treatment programme, the purposes of which shall be to ensure the person is aware of the programme’s services that may assist in overcoming drug dependence and to determine whether the person wishes to avail himself or herself of the services of the programme. The Commission may not compel the person to undergo drug dependence treatment.

OR:

Option 2: Non-custodial sentencing measures

(1) Notwithstanding the provisions of this or any other statute, where
(a) a person is found guilty in a court of law of the offence of possession of a narcotic or psychotropic substance contrary to the law;
(b) in the court’s opinion, taking into account the quantity of the substance possessed and all other relevant circumstances of the case, the use or possession of a narcotic or psychotropic substance was for the purpose of personal use; and
(c) the applicable sentence would ordinarily include a custodial sentence;

a court shall, rather than imposing a custodial sentence, order one or more of the following: 
(a) direct that the person be discharged absolutely or on the conditions prescribed in a probation order;
(b) suspend the passing of sentence and direct that the person be released on the conditions prescribed in a probation order;
(c) fine the person, if the court is satisfied that the person is able to pay the fine;
(d) order that the person serve the sentence through community service, subject to the person’s complying with the conditions of a conditional sentence order; or
(e) make a supervised attendance order with the consent of the person requiring him or her to attend a place of supervision for such time as is specified in the order and, during that time, to carry out such instructions as may be given to him by the supervising officer within the lawful exercise of that officer’s authority.

(2) As a term of a probation order or a conditional sentence order in Section (1), the court may order that the person attend a specified number of meetings with the provider of a drug dependence treatment programme, the purposes of which shall be to ensure the person is aware of the programme’s services that may assist in overcoming drug dependence and to determine whether the person wishes to avail himself or herself of the services of the programme. The court may not compel the person to undergo drug dependence treatment.

(3) The court may make an order as described in Section (1) if the court considers it to be in the best interests of the accused and not contrary to the public interest, having regard to the age and character of the offender, the nature of the offence and the circumstances surrounding its commission. In making such a determination, the court shall consider the results of any clinical assessment that may have been made of the person.

Recommendation 6: Ensure policing practices do not undermine health services to reduce harms associated with drug use

While various offences related to drugs remain in place, the way in which such laws are enforced can have a significant impact in helping or hindering public health, including measures to prevent HIV among drug users. Hence the importance of the recommendation (Recommendation 2 above) that there be a clear direction, including even in legislation, that harm reduction is a key element of the national strategies
on HIV and on drugs, and that bodies responsible for enforcing drug laws are to cooperate with health authorities in seeing such measures succeed. For a specific example, consider that police patrols around drugstores and the sites of harm reduction programmes can serve to deter people from seeking those services (e.g., to get sterile syringes) and thereby undermines public health by contributing to the risks of HIV and other harms from drug use. It is recommended that instructions to and training for law enforcement bodies and personnel explicitly instruct police not to patrol closely such facilities.

**Recommendation 7: Preclude criminal or administrative liability for harm reduction programmes**

In order to ensure they are most effective in advancing their mandate of protecting and promoting health, the harm reduction and outreach activities of non-governmental organizations targeting people who use drugs, such as programmes providing sterile syringes or other equipment to reduce harms associated with drug use (including HIV transmission), should be clearly exempt from possible legal liability.

To this end, the national expert group recommends a legislative amendment to add the following text to Article 296 of the *Criminal Code* (specifically in relation to the offence of “inducing consumption”):

> The present article does not apply to cases of distributing information aimed at preventing infection with HIV or other infectious diseases among people who use narcotic or psychotropic substances or the distribution of corresponding tools and equipment for this purpose.

It is suggested that this recommendation should also extend to other aspects of the law which create a similar risk of legal liability, which should be addressed in a similar fashion. In particular, harm reduction programmes also should be clearly exempt from liability for “propagation of narcotics” under the *Law on narcotics* (Article 47) and exempt from liability for the offence of "organizing or maintaining sites" for the consumption of such substances (*Criminal Code*, Article 297). Wording such as the proposal above from the national expert group could easily be added to these other existing provisions as well, to achieve the same effect.

**Recommendation 8: Avoid confiscation of equipment distributed by harm reduction programmes**

The national expert group also expressed specific concern about ensuring that harm reduction programmes not be undermined by law enforcement personnel confiscating from people who use drugs the information and materials they receive from these programmes, such as syringes. To this end, the group recommends that Article 45 of the *Law on narcotics* (which provides for confiscation of equipment used for consuming drugs) be amended to make it clear that this does not cover sterile injection equipment and other items provided by harm reduction programmes (including those run by NGOs) with the objective of preventing HIV infection and other harms. This could be done by adding the following provision to Article 45:

> The present article does not authorize confiscation of items distributed by harm reduction programmes with the objective of preventing infection with HIV or other infectious diseases among people who use narcotic or psychotropic substances.

**Recommendation 9: Eliminate penalty for possession of used drug equipment**

If someone stopped by police can face criminal or administrative liability for possessing drug equipment after it has been used, based on residual amounts of the drug found in or on the equipment, then this makes it less likely that people will dispose safely of such equipment after using drugs. This means they will be less likely to return used equipment to health services such as needle and syringe programmes where they can obtain new, sterile equipment. Disposing quickly of such equipment also means that a person with no equipment in hand is likely to be at greater risk of sharing someone else’s equipment in future. The national expert group expressed concern about this potential to undermine the benefit of
needle and syringe programmes, and has recommended legislative amendments to avoid this interference with harm reduction measures. To this end, legislative provisions such as the following should be enacted (perhaps by adding it to the Law on narcotics):

**No penalty for possession of residual amounts of substances in drug use equipment**

A person who is in possession of any residual amount of a prohibited narcotic or psychotropic substance that is contained in or on a syringe or other equipment used to ingest such a substance does not, by the mere fact of that possession, commit an offence under any law.

**Recommendation 10: Limit compulsory drug testing**

Currently, even though drug use is not a punishable offence, the law allows compulsory drug testing to detect drug use in various circumstances, even based on a simple suspicion of drug use. The national expert group and the technical advisors have concluded that the current provisions of the Law on narcotics that provide for widespread use of compulsory drug testing encourage people who use drugs “to go clandestine” and avoid health services, including seeking medical assistance in circumstances where overdose occurs. By contributing to the further marginalization of drug users from health services, such measures contribute to their risk of HIV infection and the spread of HIV. As outlined above, such provisions infringe numerous human rights. Among other things, compulsory drug testing violates privacy and security of the person, without justification in most circumstances, since merely showing past use of drugs does not prove there is a risk of harm to self or others, which should be the only basis for possibly justifying an intrusion by the state into such rights.

It is therefore recommended to introduce changes to Article 50 of the Law on narcotics to limit the application of compulsory drug testing. The law should at least be amended to limit compulsory testing to only those circumstances in which a person has committed an illegal act. To this end, the national expert group has suggested striking out paragraphs 1-2 of Article 50 of the Law on narcotics and substituting the following wording:

**Compulsory medical examination on drugs (testing) is prohibited, unless by police in case of suspicion that a person has committed an illegal act; or by court order in circumstances provided by the law.**

However, the government should also consider going further, by eliminating any use of compulsory drug testing linked to criminal or administrative offence. Instead, as suggested above, such invasion of people’s bodies and privacy should be limited to only those circumstances in which there is a clear, defensible assessment that the person is at imminent risk of harming himself/herself or others.

**Drug dependence treatment**

**Recommendation 11: Introduce opioid substitution therapy as one element of a comprehensive approach to drug dependence treatment**

The national expert group has noted that currently opioid substitution treatment (OST) is not available as a treatment method for people with drug dependence, either in the community at large or for prisoners, but that the possibility of introducing a pilot project (outside prison) is under discussion. The national expert group and the technical advisors recommend that OST be introduced in Turkmenistan as one option for treatment, with legislative amendments to the Law on narcotics should these prove necessary. To achieve this, a provision such as the following should be added:

**Opioid substitution as a component of drug dependence treatment**

As one important element of protecting and promoting the health of people who use prohibited substances, including reducing the risks of HIV transmission associated with drug injecting, the

---

Ministry of Health and Medical Industry is responsible for ensuring access to medications for opioid substitution treatment, as one aspect of treatment for those with dependence on opioids.

It is also recommended that medications such as methadone and buprenorphine be registered for prescription in Turkmenistan and added to the national list of essential medicines.

**Recommendation 12: Improve access to voluntary treatment**

The national expert group has recognized that notwithstanding general statements in the law about protecting confidentiality of patients’ health information, there are infringements of said confidentiality. Concern about loss of confidentiality, including providing information to law enforcement that can result in prosecution for administrative or criminal offences, is an obvious disincentive to seeking treatment. The national expert group recommends that the government organize and support a network of sites providing greater access to drug dependence treatment that is voluntary, free and anonymous.

**Recommendation 13: Revisit operation of drug user registry, protect confidentiality**

Currently, for people receiving drug dependence treatment, there are unjustifiably broad exceptions to the general requirement of maintaining medical confidentiality of patients — including disclosure of patient information to law enforcement bodies upon request, and an obligation to report cases of overdose and those seeking treatment for drug dependence to law enforcement bodies. The national expert group and the project technical advisors observe that the current system of registration of drug users is one factor that discourages people from seeking medical treatment, including for drug dependence, and provides a basis for various infringements of confidentiality. It is therefore recommended that the government begin an assessment of the efficacy and cost-effectiveness of the current approach. This should be included in a consultation process about reforming Turkmenistan's drug policy and practices with a view to reforming the system to ensure it is effective in protecting and promoting health and in respecting and protecting human rights. To protect confidentiality better, legislative provisions such as the following could be added to the *Law on narcotics* and/or the *Law on health protection of citizens*:

**Confidentiality of patients’ information**

1. The confidentiality of all health care information shall be respected. Records of the identity, diagnosis, prognosis or treatment of any patient which are created or obtained in the course of drug dependence treatment:
   - (a) are confidential;
   - (b) are not open to public inspection or disclosure;
   - (c) shall not be shared with other individuals or agencies without the consent of the person to whom the record relates; and
   - (d) shall not be discoverable or admissible during legal proceedings.

2. No record referred to in Section (1) may be used to
   - (a) initiate or substantiate any criminal charges against a patient; or
   - (b) act as grounds for conducting any investigation of a patient.

**Recommendation 14: Address overdose among people who use drugs**

First, it is recommended to repeal the Order of the Ministry of Health and Medical Industry No.300 (14 October 2000) which provides for notification by medical workers of law-enforcement bodies if there is suspicion of poisoning with drugs. The legislation should contain prohibition of violation of patients’ privacy and provide for legal liability in case of confidentiality is violated; there may be some exceptional, narrow circumstances in which breaching confidentiality may be justified and these should be clearly set out in the law as limited exceptions.
Second, the national expert group has recommended that medical personnel (including prison staff) receive training in diagnosing and providing emergency treatment for overdose.

Third, it is recommended that naloxone, which can be used to reverse opioid overdoses (that might otherwise be fatal), be registered for use in Turkmenistan. It should be made available for use by health care workers, who should also receive training on its use. Consideration should also be given to making naloxone, and information on its use to reverse overdoses, available to outreach workers from harm reduction programmes and to people who use opioids or whose acquaintances are at risk of overdose. It is also recommended to allow peer educators among prisoners and prison staff to administer naloxone in case of overdose in penitentiary institutions, and train them to use this emergency response medication.

**Recommendation 15: Ensure women’s access to voluntary drug dependence treatment**

Currently, the national programme against drugs contains a proposal to open a hospital for compulsory drug dependence treatment for women. The national expert group and the project technical advisors have recommended replacing this paragraph in the programme with a commitment “to improve the provision of assistance to women with drug dependence by expanding the network of anonymous, free, voluntary services for counselling and drug dependence treatment and including facilities specifically intended to provide services to women.”

**Recommendation 16: Limit the use of compulsory treatment (drug dependence and HIV and other)**

Under current Turkmen law, compulsory treatment may be imposed in a wide range of circumstances, including on:

- any person with HIV (because it is designated as a “dangerous infectious disease”);¹²³⁷
- anyone with drug dependence who evades medical treatment and continues to use narcotics;¹²³⁸
- any prisoner.

But international organizations underline the principle that drug dependence treatment should generally be voluntary.¹²³⁹ As a general proposition, compulsory medical treatment violates human rights, including to liberty, security of the person and privacy,¹²⁴⁰ and should be applied only in extreme, clearly defined cases with a view to preventing a person from causing imminent serious harm to himself/herself or to others. It is recommended that the Ministry of Health and Medical Industry review the efficacy and costs of current approaches to compulsory drug treatment, the experience of other jurisdictions (including protections to ensure that compulsory treatment is limited to exceptional circumstances), and bring forward a number of legislative amendments.

First, the government should amend the law to remove HIV from the list of “dangerous infectious diseases” that automatically subject any person living with HIV to the possibility of compulsory treatment.

Second, the government should consider enacting legislation such as the following to ensure treatment is done in accord with good practice and human rights norms:

**Basic rights of patients**

Every patient has the right:

¹²³⁷ Law on health protection of citizens, Article 28.
¹²³⁸ Law on narcotics, Article 42; Criminal Code, Article 94.
(a) to a full course of high-quality treatment and follow-up support to be provided in accordance with good clinical practice;
(b) to treatment without discrimination;
(c) to meaningful participation in determining his or her own treatment goals, which may include but are not limited to abstinence or changes in drug use that minimize the harms of dependence;
(d) to meaningful participation in all treatment decisions, including when and how treatment is initiated and withdrawal from treatment;
(e) to exercise his or her rights as a patient, including:
   (i) reporting, without retribution, any instances of suspected abuse, neglect, or exploitation of patients in the programme;
   (ii) a grievance and appeal process, in accordance with national laws and regulations;
   (iii) input into the policies and services of drug dependence treatment programmes; and
   (iv) voluntary withdrawal from treatment at any time.
(f) to confidentiality of medical records and clinical test results; and
(g) to be fully informed, including but not limited to the right to receive information on:
   (i) his or her state of health;
   (ii) his or her rights and obligations as a patient, as specified in this Part and in applicable law;
   (iii) the procedure for making a complaint about the services received through the programme; and
   (iv) cost and payment conditions and the availability of medical insurance and other possible subsidies.

**Informed consent**

(1) Informed voluntary consent of a patient is a necessary preliminary condition for medical treatment or a preventive or diagnostic intervention.

(2) The following are the elements required for consent to treatment:
   (a) the consent must relate specifically to the treatment administered;
   (b) the consent must be fully informed;
   (c) the consent must be given voluntarily;
   (d) the consent must be provided in writing; and
   (e) the consent must not be obtained through misrepresentation or fraud.

(3) A consent to treatment is fully informed if, before giving it:
   (a) the person received the information about the matters set out in Section (4) that a reasonable person in the same circumstances would require in order to make a decision about the treatment; and
   (b) the person received responses to his or her requests for additional information about those matters.

(4) The matters referred to in Section (3) are:
   2. The expected benefits of the treatment.
   3. The material risks of the treatment.
   4. The material side effects of the treatment.
   5. Alternative courses of action.
   6. The likely consequences of not having the treatment.

**Withdrawal from treatment**

(1) A patient shall have the right to withdraw voluntarily from treatment at any time.

(2) The health practitioner shall fully inform the patient of the potential risks and benefits of withdrawal from treatment and shall work with the patient to ensure the patient’s safety and comfort during the withdrawal process.
(3) The health practitioner shall not discontinue services that are needed unless the patient requests the discontinuation, alternate services are arranged, or the patient is given a reasonable opportunity to arrange alternate services.

(4) The withdrawal from treatment with an explanation of likely consequences shall be recorded or registered in medical documentation and signed by the patient and health practitioner.

(5) Involuntary withdrawal from treatment shall be avoided except where compelling reasons exist. Regulations governing grounds for involuntary withdrawal shall be clearly communicated to patients at the outset of treatment.

HIV prevention and treatment

Recommendation 17: Strengthen legal framework for harm reduction measures to prevent HIV among vulnerable populations

While official statistics indicate very low HIV prevalence currently in Turkmenistan, HIV risk behaviours are well documented, meaning it is important to take proactive steps now to prevent HIV from becoming more widespread, particularly among groups at elevated risk. To this end, the government should strengthen the existing Law on prevention of HIV by legislatively mandating measures to reduce harms, including HIV infection, particularly among people who use drugs and people who use drugs and people in prison or in detention facilities. This should include high-level directives specifically to government bodies and agencies such as the Ministry of Health and Medical Industry (which is responsible for health generally) and the Ministry of Internal Affairs (which has responsibility for ensuring the health of prisoners), to take the primary lead on ensuring such measures are implemented. Directives should also issue that clearly direct law enforcement bodies (including the State Coordination Commission on the Fight Against Narcotic Addiction) to cooperate with other government bodies and with non-governmental organizations to ensure the effective delivery and operation of harm reduction services (e.g., sterile syringe programmes, OST). The numerous other specific legislative amendments proposed in this report are aimed at creating such a supportive legal framework.

But it would also be advisable to have a clear, overarching statement in both the Law on prevention of HIV and the Law on narcotics clearly articulating this objective, and that harm reduction programmes and services are an important element of pursuing this objective. A legislative provision such as the following should be added to these two statutes:

Harm reduction an essential element in national health and drug policy

(1) Preventing and reducing the spread of HIV, other blood-borne and sexually transmitted infections, and other harms is a key objective of national health policy and national policy on illicit drugs. Health services and programmes, operated and delivered by both public authorities and non-governmental organizations with these objectives, are necessary and important elements of implementing such policy, particularly in addressing these individual and public health concerns among groups that face an elevated risk of such harms, including but not limited to people who use narcotics and psychotropic substances and people in prisons or other places of detention.

(2) Public authorities responsible for health, including the health of these groups, will act to implement such services described in section (1), based on the best available evidence of need and efficacy and in accordance with human rights obligations. Other public authorities, including those responsible for enforcement of laws on narcotics and psychotropic substances, will cooperate in pursuing these health objectives.

Recommendation 18: Limit the use of compulsory HIV testing

If HIV testing is ever to be imposed without consent, then it requires a process clearly set out in law, with a requirement that such measures be taken only in exceptional circumstances and with adequate justification that must be considered by an independent, judicial body, and with the most limited infringement of
human rights possible. However, the national programme against AIDS currently calls for obligatory HIV testing of people with drug dependence and of pregnant women. Such testing unjustifiably infringes human rights to security of the person, privacy, and equality. It is recommended to remove this direction from the national programme against AIDS.

In addition, the Law on prevention of HIV currently provides for obligatory HIV testing for a wide range of people, including people who use drugs and who are receiving drug dependence treatment, people with other diagnosed STIs or with TB, prisoners, sex workers, foreign citizens staying in Turkmenistan longer than three months, pregnant women, and a large number of health workers. This widespread use of obligatory HIV testing is not a good use of resources and also infringes human rights norms for many people. In accordance with international standards, it is recommended to amend the Law on prevention of HIV to clearly prohibit obligatory HIV testing except in the case of donors of blood, organs or other bodily tissues or substances. Adding a legislative provision such as the following would be advisable:

**Voluntariness of HIV testing**

1. Every person is entitled to free confidential [or anonymous] testing for infection with HIV, other blood-borne infections or other sexually transmitted infections, and to counselling in connection with such testing.

2. No test for HIV, other blood-borne infection or other sexually transmitted infection shall be undertaken except with the informed voluntary consent in writing of the person being tested.

3. All persons presenting themselves for testing shall be offered pre-test and post-test counselling by a health practitioners, in accordance with professional standards.

**Recommendation 19: Respect patients’ rights (to privacy)**

Currently, the law imposes legal liability on a person diagnosed with an STI (presumably including HIV) for not identifying past sexual contacts (Code of Administrative Offences, Article 46). It is difficult to see how this could be effectively enforced in any verifiable way; given this, and that it invades patients’ rights to privacy with a significant penalty, this aspect of the law should be reformed, by repealing Article 46 of the Code of Administrative Offences.

**Recommendation 20: Respect patients’ rights (to security of the person)**

Currently, the law makes a person potentially administratively or criminally liable for “evading” testing for "venereal diseases" and for "evading" treatment if diagnosed with a STI [presumably including HIV] (Criminal Code, Articles 117-118; Administrative Code Article 46). The Law on health protection of citizens also provides for treatment without a patient’s consent in the case of "diseases representing a danger to others", which has been defined to include HIV. However, except in very limited circumstances, involuntary medical treatment is not consistent with human rights, which require that a patient give informed, fully voluntary consent to treatment. It is recommended that these provisions be repealed.

**Recommendation 21: Ensure access to treatment for people living with HIV**

According to the Law on prevention of HIV (Article 10), people with HIV receiving out-patient treatment are entitled to free medications, including antiretroviral (ARV) therapies. However, as of this writing in December 2008, ARV therapy is not available in Turkmenistan, according to the national expert group. The Ministry

---

1241 Guidelines such as the UN’s Siracusa Principles on permissible limitations on human rights should be complied with in any legislative provision that would allow involuntary testing or treatment: UN Economic and Social Council, Siracusa Principles on the Limitation and Derogation Provisions in the International Covenant on Civil and Political Rights, UN Doc. E/CN.4/1985/4, Annex (1985).

1242 Law on prevention of HIV, Article 11.

1243 It should be noted, however, that ARV treatment is reportedly not available in Turkmenistan, so it is difficult to see how such treatment could be enforced upon anyone at this time.
of Health and Medical Industry should move immediately to ensure that all necessary legal steps have been taken to prescribe ARVs to patients (e.g., registering such medicines for use in Turkmenistan) and that such medications are available for prescription, with the consent of the patient, when clinically recommended. It is also recommended to include ARV medication in the National List of Essential Medicines.

Prisons

Recommendation 22: Create legislative framework to address health needs in prisons, including for people with HIV and with drug dependence

The national expert group has observed that the current penal legislation of Turkmenistan, including the Corrective Labour Code, does not include provisions ensuring access to care for persons with HIV and narcotic addiction in correctional institutions, nor the introduction of harm reduction programmes or pre- and post-release programmes for rehabilitation of those with drug dependence. The national expert group has recommended enacting a set of clear legislative provisions that address these issues and that mandate the implementation of such health measures by the Ministry of Internal Affairs and the Ministry of Health and Medical Industry. This will likely necessary changes to the “Internal regulations of penitentiary institutions” regarding prisoners’ rights to obtain and possess HIV prevention materials.

In particular, the national expert group has recommended specific attention to the following concerns:

- ensuring access to information materials and training for prisoners and prison personnel on HIV, STIs, and other health issues;
- introducing harm reduction measures for prisoners, including access to opioids substitution therapy and distribution of sterile syringes;
- ensuring access to condoms and disinfectants (e.g., bleach) for prisoners (while also abolition the prohibition on consensual sexual activity between adults of the same sex); and
- training prison personnel in required information and recommendations for prisoners before release.

To this end, legislative provisions such as the following should be enacted (e.g., in the Corrective Labour Code):

**Article 1. Purpose of this Part [of the Code]**

The purpose of this Part [of the Code] is to contribute to a safe and healthy environment for prisoners and prison staff by:

(a) providing prisoners with humane treatment and support for HIV/AIDS and other blood borne diseases, and for drug dependence, in an environment free of discrimination;
(b) enabling a wide range of services for prisoners to minimize the harms related to unsafe drug use, including the risk of infection by HIV and other blood-borne diseases;
(c) developing a safer work environment for prison staff; and
(d) providing for the development of national data and research on the prevalence of sexual violence (including rape) in prison and the issuance of national standards to eradicate sexual violence in prison.

**Article 2. Definitions**

For the purposes of this Part, the following definitions are used:

“Cruel, inhuman or degrading treatment or punishment” means any harsh or neglectful treatment that could damage a person’s physical or mental health, or any punishment intended to cause physical or mental pain or suffering, or to humiliate or degrade the person concerned.

---

“Dispensing machine” means any machine or mechanical device used for selling or supplying sterile syringes without the personal attention of the seller or supplier at the time of the sale or supply.

“Drug dependence treatment” means a programme with specific medical or psycho-social techniques aimed at managing or reducing a patient’s dependence on one or more controlled substances, thereby improving the general health of the patient. Such programmes include opioid substitution treatment, residential or out-patient services, administration of medicines to reduce cravings or diminish an adverse impact of using controlled substances, psychiatric and psychosocial support services and supervised support groups.

“Health care” refers to services provided by health professionals in the formal health system for prevention or treatment of mental or physical diseases or conditions.

“Health practitioner” means a person entitled under the [relevant health law] to provide health services. Health practitioners include accredited physicians, registered nurses and other trained medical staff.

“Opioid substitution treatment” means the administration of an opioid substitute to a person with dependence on a pharmacologically related opioid, for achieving defined treatment aims, including maintenance treatment.

“Parole” means the authority granted to a prisoner by the [relevant authority] to be in the general community during the prisoner’s sentence, and may include day parole.

“Prison” includes

(a) a facility of any description that is operated, permanently or temporarily, by the Ministry of Internal Affairs for the care and custody of prisoners; and
(b) a private prison facility constructed or operated under an agreement with the relevant prison authority for the confinement of prisoners.

“Prisoner” includes

(a) a person who is in a prison pursuant to a sentence for an offence; or who has been convicted of an offence and is awaiting imposition of a sentence; or who is in prison because of a condition imposed by the [relevant authority] in connection with parole or statutory release;
(b) a person who, having been sentenced, committed or transferred to prison, is temporarily outside prison by reason of a temporary absence or work release authorized under [relevant legislation]; or is temporarily outside prison for reasons other than a temporary absence, work release, parole or statutory release, but is under the direction or supervision of a staff member or of a person authorized by the [relevant authority]; and
(c) a person who is in prison awaiting trial.

“Staff”, in the context of a sterile syringe programme, includes the following persons:

(a) the operator or manager of the programme;
(b) a person engaged by the operator or manager of the programme to provide services at the facility, whether under a contract of employment or otherwise; and
(c) a person engaged by the operator or manager of the programme to provide voluntary assistance at the facility.

“Sexual violence” means an act of sexual violence, including rape, committed against a prisoner who is in the actual or constructive control of prison officials.
“Sterile syringe programme” means a programme that provides access to sterile syringes and other related material, information on HIV transmission and other blood-borne pathogens, or referrals to substance abuse treatment services. It includes needle exchange programmes, needle distribution programmes and other forms of sterile syringe distribution.

“Torture” means any act by which severe pain or suffering, whether physical or mental, is intentionally inflicted on a person for such purposes as obtaining from the person or a third person information or a confession; punishing the person for an act he or she or a third person has committed or is suspected of having committed; or intimidating or coercing the person or a third person; or for any reason based on discrimination of any kind, when such pain or suffering is inflicted by, at the instigation of, or with the consent or acquiescence of, a public official or other person acting in an official capacity. It does not include pain or suffering arising only from, inherent in, or incidental to, lawful sanctions.

Article 3. Human rights governing the procedure and conditions of imprisonment

(1) The state shall respect and protect the human rights and fundamental freedoms of prisoners and shall provide the conditions necessary for their social, legal and medical protection and care.

(2) Except for those limitations that are demonstrably necessitated by the fact of imprisonment, all prisoners shall retain the human rights and fundamental freedoms set out in international human rights law.

Article 4. Rights upon arrest or detention

(1) Anyone arrested or detained on a criminal charge shall be brought promptly before a judge or other officer authorized by law to exercise judicial power and shall be entitled to trial within a reasonable time and without undue delay or to release.

(2) Pre-trial detention shall be used as a means of last resort in criminal proceedings, with due regard for the investigation of the alleged offence and for the protection of society and the victim.

(3) Pre-trial prisoners and others under detention without sentence are entitled to the same rights as sentenced prisoners, including those rights related to health care.

Article 5. Right to equal and adequate health care for prisoners

(1) A prisoner who has tested positive for infection with HIV is entitled to adequate health care, counselling and referrals to support services while in prison.

(2) Health practitioners shall provide prisoners with protection of their physical and mental health and treatment of disease of the same quality and standard as is afforded to those who are not imprisoned or detained.

Article 6. Voluntary counselling and testing

(1) A prisoner is entitled to free confidential testing for infection with HIV and other blood-borne viruses, and to counselling in connection with such testing.

(2) No test for HIV or other blood-borne disease shall be undertaken except with the informed voluntary consent in writing of the prisoner.

(3) All prisoners presenting themselves for testing shall be offered pre-test and post-test counselling by a health practitioner, in accordance with professional standards.
Article 7. Informed consent

(1) Informed voluntary consent of a prisoner is a necessary preliminary condition for medical treatment or a preventative or diagnostic intervention.

(2) The following are the elements required for consent to treatment:

(a) the consent must relate specifically to the treatment administered;
(b) the consent must be fully informed;
(c) the consent must be given voluntarily;
(d) the consent must be provided in writing; and
(e) the consent must not be obtained through misrepresentation or fraud.

(3) For the purpose of paragraph (2)(b), a prisoner’s consent to a health care intervention or procedure is informed consent only if the prisoner has been advised of, and has the capacity to understand:

(a) the likelihood and degree of improvement, remission, control or cure as a result of the intervention;
(b) any significant health or other risk, and the degree thereof, associated with the intervention;
(c) any reasonable alternatives to the intervention;
(d) the likely effects of refusing the intervention; and
(e) the prisoner’s right to refuse the intervention or withdraw from the intervention at any time.

(4) The prisoner has the right to refuse health care interventions or withdraw from health care interventions at any time. If the prisoner refuses to consent to a specific intervention or procedure, no punitive action shall be taken and medically appropriate alternative interventions or procedures shall, if possible, be made available.

Article 8. Confidentiality

(1) All information on the health status and health care of a prisoner is confidential, and all health care procedures shall be designed so as to preserve the confidentiality of prisoners.

(2) Information referred to in Section (1) shall be recorded in files available only to health practitioners and not to non-health care prison staff. No mark, label, stamp or other visible sign shall be placed on prisoner’s files, cells or papers that could indicate his or her HIV status, other than necessary notations inside the medical file in accordance with standard professional practice for recording clinically relevant information about a patient.

(3) Information referred to in Section (1) may only be disclosed:

(a) with the prisoner’s consent; or
(b) where warranted to ensure the safety of other prisoners or staff;

with the same principles as generally applied in the community applying to the disclosure.

Article 9. Prohibition of torture and other cruel, inhuman or degrading treatment or punishment

Every health practitioner, or every person acting at the instigation of or with the consent or acquiescence of an health practitioner, who inflicts torture or cruel, inhuman or degrading treatment or punishment on any other person is guilty of an offence [under the Criminal Code] and liable to imprisonment for a term not exceeding [x].
Article 10. No discrimination against prisoners on the basis of HIV or HCV status

(1) In all prison facilities, it shall be illegal to discriminate against a prisoner on the basis of his or her infection with HIV or diagnosis of AIDS, or his or her infection with hepatitis C.

(2) Prisoners living with HIV/AIDS or HCV shall:

(a) be housed with the general prisoner population, unless they require a level of health care which cannot be provided in such a setting or unless separate housing is necessary for their protection from other prisoners;

(b) be offered the same opportunities as other prisoners to participate in educational, job, vocational or other programmes, except where limitations to a specific assignment are clinically indicated; and

(c) have access to the full range of available institutional counselling and support services and, to the greatest extent possible, to local community counselling and support services.

Article 11. Review of prison policies and practices regarding HIV/AIDS, other blood-borne diseases and drug dependence treatment

(1) The Ministry of Health and Medical Industry is hereby authorized and directed to review any policy or practice instituted in facilities operated by the Ministry of Internal Affairs regarding HIV/AIDS, other blood-borne diseases and drug dependence, including the prevention of the transmission of HIV and other blood-borne diseases and the treatment of prisoners living with HIV/AIDS, other blood-borne diseases or drug dependence.

(2) Such review shall be performed annually and shall focus on whether such policy or practice is consistent with current, generally accepted medical standards and procedures used in the general population to prevent the transmission of HIV and other blood-borne diseases and to treat persons living with HIV/AIDS, other blood-borne diseases or drug dependence.

(3) Upon the completion of such review, the Ministry of Health and Medical Industry shall, in writing, report to the Ministry of Internal Affairs on such policy or practice as instituted in facilities operated by the latter. The report may direct the Ministry of Internal Affairs to prepare and implement a corrective plan to address deficiencies in areas where such policy or practice fails to conform to current, generally accepted medical standards and procedures. The Ministry of Health and Medical Industry shall monitor the implementation of such corrective plans and shall conduct such further reviews as it deems necessary to ensure that identified deficiencies in policies and practices regarding HIV/AIDS, other blood-borne diseases and drug dependence are corrected.

(4) All written reports pertaining to such reviews provided for in this section shall be maintained as public information available for public inspection.

Article 12. Distribution and possession of condoms and other safer sex materials in prisons

(1) The Ministry of Health and Medical Industry, with the cooperation of the Ministry of Internal Affairs, shall ensure that condoms and other safer sex materials, such as water-based lubricants and dental dams, along with appropriate information on their proper use and on their importance in preventing the spread of HIV infection and other sexually transmitted infections, are made available and easily accessible to prisoners in a manner that protects their anonymity.

(2) The Ministries shall develop a plan for the disposal of used condoms that protects the anonymity of prisoners and the health of prison officers.

(3) The distribution and possession of condoms and other safer sex materials in prisons in accord-
ance with this Part shall not constitute a criminal nor administrative offence, nor are condoms and other safer sex materials admissible as evidence of sexual relations for the purposes of determining any criminal or administrative offence.

**Article 13. Authorization of sterile syringe programmes**

(1) Sterile syringe programmes shall be implemented in all prisons according to the provisions set out herein, with the objective of reducing harms associated with unsafe use of drugs, including the risk of transmission of HIV or other blood-borne diseases.

(2) The Ministry of Health and Medical Industry may authorize a specified person or organization to supply:

(a) sterile syringes and other related material to prisoners; and
(b) information concerning hygienic practices in the use of syringes and other related material;

in order to prevent the spread of blood-borne diseases and minimize the health risks associated with injection drug use by prisoners.

**Article 14. Supply of sterile syringes and other related materials**

Staff of a sterile syringe programme may provide the following material:

(a) sterile syringes and other related material for safer injection drug use, including sterile water ampoules, swabs, filters, safe acid preparations, spoons and bowls and other appropriate materials;
(b) material to enable safer smoking and inhalation of drugs, such as pipes, stems, metal screens, alcohol wipes and lip balm; and
(c) condoms and other safer sex materials such as water-based lubricants and dental dams, as well as information about reducing the risks of HIV and other sexually transmitted infections.

**Article 15. Information**

Staff of sterile syringe programmes may provide information including, but not limited to, the following:

(a) drug dependence treatment services and other health services;
(b) means of protection against transmissible diseases, including blood-borne diseases such as HIV;
(c) the risks associated with the use of controlled substances;
(d) harm reduction information specific to the drug being used, including safe injecting and inhaling practices;
(e) legal aid services;
(f) employment and vocational training services and centres; and
(g) available support services for people with drug dependence and their families.

**Article 16. Distribution and possession of sterile syringes and related material**

(1) An authorized person or organization may distribute sterile syringes and related material via one or more of the following means:

(a) prison nurses or physicians based in a medical unit or other area(s) of the prison;
(b) prisoners trained as peer outreach workers;
(c) non-governmental organizations or health professionals who enter the prison for this purpose;
(d) one-for-one automated sterile syringe-dispensing machines.
(2) Wherever possible, sterile syringes and related material shall be made available to prisoners without the necessity of the prisoner identifying himself or herself to prison authorities.

(3) The Ministry of Internal Affairs shall establish rules for the safe storage of syringes possessed by prisoners in accordance with the provisions of this Part.

(4) The sterile syringe programme shall include measures to encourage safe disposal of syringes and monitor the number of syringes distributed and the number in storage.

(5) Sterile syringes and related material distributed pursuant to this Part shall be used only in accordance with this Part and any other applicable Regulations or institutional policies established pursuant to this Part.

(6) The distribution and possession of syringes and related material in prison in accordance with this Part shall not constitute a criminal or administrative offence, nor shall such items be admissible as evidence of illegal drug use for the purposes of determining any criminal or administrative offence.

Article 17. Availability of bleach as a disinfectant

(1) Bleach and instructions on using bleach as a disinfectant shall be made available in accordance with this Part and any other applicable Regulations or institutional policies established pursuant to this Part.

(2) Any such Regulations or policies established pursuant to Section (1) will:

(a) encourage participation of prisoners and their assistance in bleach distribution;
(b) ensure that bleach is available to prisoners in ways that preserve prisoners’ anonymity; and
(c) ensure that in no instance shall a prisoner be required to approach a staff member in order to obtain bleach.

(3) Bleach distributed pursuant to this Part shall be used only in accordance with this Part and any other applicable Regulations or institutional policies established pursuant to this Part.

(4) The distribution and possession of bleach in prison in accordance with this Part shall not constitute a criminal or administrative offence, nor shall such items be admissible as evidence of illegal drug use for the purposes of determining any criminal or administrative offence.

Article 18. Opioid substitution treatment programmes in prison

(1) The Ministry of Health and Medical Industry, with the cooperation of the Ministry of Internal Affairs, shall establish opioid substitution treatment programmes in all prisons.

(2) Prisoners with opioid dependence shall be eligible for opioid substitution treatment in accordance with opioid substitution treatment guidelines applicable in the community.

(3) Opioid substitution treatment shall be available for free on imprisonment and throughout the duration of imprisonment.

(4) Opioid substitution treatment shall not be restricted to those on a course of opioid substitution treatment prior to imprisonment; all prisoners shall be entitled, if eligible, to being on opioid substitution treatment while incarcerated.

(5) Participation in the opioid substitution treatment programmes shall be offered on a voluntary basis to all prisoners with opioid dependence.

(6) Opioid substitution treatment programmes may include a variety of approaches, including maintenance treatment.
(7) The programme shall ensure that staff members, prison officers, policy makers and prisoners have factual information regarding opioid substitution treatment.

(8) The programme shall develop a comprehensive discharge planning system for prisoners nearing release, including a system for referral to opioid substitution treatment programmes in the general community.

**Article 19. Information and education programmes regarding HIV/AIDS, other blood-borne diseases and drug dependence treatment in prisons**

(1) The Ministry of Health and Medical Industry shall develop and implement information and education programmes in every prison to help prevent the spread of HIV, other blood-borne diseases, and to address drug dependence among prisoners.

(2) In developing such programmes, the Ministry shall use materials that are likely to be effective in reducing transmission of blood-borne diseases within prisons and outside prison following the release of prisoners, as well as providing information on treatment, care and support.

(3) Such programmes required by Section (1) may include peer education and use of non-Ministry personnel, including delivery of these programmes by community-based organizations.

(4) Materials shall, as much as possible, be available in the languages of the relevant populations, shall take into account the literacy level of the relevant populations, and shall be sensitive to the social and cultural needs of the relevant populations.

**Article 20. Responsibility for providing training and education**

The Ministry of Health and Medical Industry is responsible for ensuring, with the cooperation of the Ministry of Internal Affairs:

(a) that training and education are provided to staff and prisoners on a regular basis, and that such training and education include the principles of standard precautions to prevent and control blood borne diseases; the personal responsibility of staff and prisoners to protect themselves and others at all times; and information on post-exposure prophylaxis;

(b) that training and education provided to prisoners also include available services and treatments; and peer education and counselling programmes that include the meaningful participation of prisoners as counsellors; and

(c) that prisoners and staff who may be exposed to blood and body fluids receive training in universal precautions.

**Article 21. Statistics on sexual violence (including rape) in prisons**

(1) The Ministry of Health and Medical Industry shall carry out, at regular intervals, a comprehensive statistical review and analysis of the incidence of sexual violence in prisons, which shall include, but not be limited to, the identification of the common characteristics of:

(a) both victims and perpetrators of sexual violence; and

(b) prisons and prison systems with a high incidence of said violence.

(2) In carrying out Section (1), the Ministry shall consider:

(a) how incidents of sexual violence will be defined for the purposes of the statistical review and analysis; and

(b) how the Ministry should collect information about sexual violence against prisoners committed by other prisoners and by staff, beyond prisoner self-reports of such violence.

(3) The Ministry shall solicit views from representatives of the following: state prison departments, county and municipal prisons, juvenile prison facilities, former prisoners, health service providers, victim advocates, researchers, and other experts in the area of sexual violence (including within prisons).
**Article 22. Development of national standards against sexual violence in prisons**

(1) The Prosecutor General, the Ministry of Internal Affairs and the Ministry of Health and Medical Industry shall develop national standards for enhancing the detection, prevention, and reduction of sexual violence (including rape) in prisons and for prosecution of offenders.

(2) The information provided under paragraph (1) shall include national standards relating to:
   (a) the classification and assignment of prisoners, using standardized instruments and protocols, in a manner that limits the occurrence of sexual violence in prison;
   (b) the investigation and resolution of prisoners’ complaints of sexual violence by responsible prison authorities, local and state police, and national and state prosecution authorities;
   (c) the preservation of physical and testimonial evidence for use in an investigation of the circumstances relating to sexual violence;
   (d) acute trauma care for victims of sexual violence, including standards relating to the manner and extent of physical examination and treatment to be provided; and the manner and extent of any psychological or psychiatric examination and care, medication or counselling to be provided;
   (e) referrals for long-term continuity of care for those who have experienced sexual violence;
   (f) educational and medical testing measures for reducing the risk of HIV transmission as a result of sexual violence in prison;
   (g) post-exposure prophylactic measures, including a short course of antiretroviral drugs, for reducing the incidence of transmission of HIV;
   (h) the training of prison staff sufficient to ensure that they appreciate the significance of sexual violence in prison and the need to prevent it;
   (i) the timely and comprehensive investigation of staff sexual misconduct involving rape or other sexual violence on prisoners;
   (j) creating a system for reporting incidents of sexual violence in prison that will ensure the confidentiality of complainants, protect prisoners who make complaints from retaliation, and assure the impartial resolution of complaints;
   (k) data collection and reporting of sexual violence (including rape) in prison, sexual misconduct toward prisoners on the part of prison staff, and the resolution of prisoners’ sexual violence complaints by prison officials and national, state, and local investigation and prosecution authorities; and
   (l) such other matters as may reasonably be related to the detection, prevention, reduction and punishment of sexual violence in prison.

**Recommendation 23: Allow compassionate release from prison based on health concerns**

In the current legislation of Turkmenistan there are provisions to ensure early release from penitentiary institutions due to illness. However, HIV and AIDS are not on the list. It is recommended that these be added, as HIV disease is a serious, chronic infection that can progress much more quickly in adverse conditions, including those in penitentiary institutions. To save the life and health of people living with HIV, those with such a diagnosis should be eligible for compassionate release. The *Corrective Labour Code* should be amended by adding a provision such as the following:

**Compassionate Release**

Conditional or unconditional release may be granted by the Ministry of Internal Affairs, or a court, at any time to a prisoner:
(a) who is terminally ill;
(b) whose physical or mental health is likely to suffer serious adverse effects if the prisoner continues to be held in confinement; or
(c) for whom continued confinement would constitute an excessive hardship that was not reasonably foreseeable at the time the prisoner was sentenced.
Discrimination

Recommendation 24: Strengthen protection against HIV-related discrimination

Discrimination against people based on HIV status is discrimination based on "other status" that goes against basic human rights norms established in international law.\(^{1245}\) It also undermines efforts to prevent the spread of HIV and ensure care, treatment and support for those who are infected. It is recommended that the Government consult key officials and national and international experts, including people living with HIV and representatives of civil society, to begin implementing reforms to existing programmes and laws that will add or strengthen measures to prohibit, prevent and provide redress for discrimination based on HIV status.

Recommendation 25: Eliminate discriminatory restrictions on travel or residence based on HIV status

Currently, HIV-positive status is a basis on which to deny a visa or residence permit to a non-citizen and to deport non-citizens from Turkmenistan. Such treatment amounts to discrimination that is not justified. It is recommended that the Government amend Article 18 of the Law on migration to remove this feature of the law.

Recommendation 26: Eliminate discrimination in employment based on HIV status

Currently, the Constitution has a very broad prohibition on discrimination, and the Law on prevention of HIV prohibits unreasonable refusal to employ, or unreasonable dismissal of, people with HIV or AIDS. This is consistent with international human rights law. Yet Turkmen law also currently restricts people from working in certain trades or occupations based on HIV-positive status, which amounts to discrimination that can rarely be justified.\(^{1246}\) To rectify this inconsistency, and to protect better the rights of people living with HIV, two steps can be taken.

- First, the Government should review existing orders or other official government documents that include HIV on a list of diseases that preclude a person from holding certain positions, and amend them to remove any reference to HIV unless there is a clear, scientifically sound basis establishing that performing such employment cannot be done without posing a significant risk to the health of another person.
- Second, a legislative amendment to the Law on prevention of HIV should be added that could be worded as follows:

\[
\text{Discriminating against a person on the basis of his or her HIV infection or AIDS diagnosis [or on the basis of other blood-borne infection] is prohibited, including but not limited to such contexts as employment [or education]. It is unlawful discrimination to require that a person be tested for HIV as a condition of employment [or enrolment in an educational institution], either before or during employment [or enrolment].}
\]

Recommendation 27: Eliminate workplace discrimination against drug-dependent persons

Testing of workers for the presence of drugs is currently carried out under the Law on narcotics and pursuant to the "National programme against drug trafficking for the period 2006-2010" (para. 34). However,

\(^{1245}\) International law guarantees equal protection of the law and protection against discrimination: International Covenant on Civil and Political Rights, Articles 2 and 26. The UN Commission on Human Rights has determined that the term “other status”, as used in the ICCPR and numerous other instruments in international human rights law in prohibiting discrimination, includes “health status”, including HIV/AIDS — that is, discrimination on the basis of health status, including on the basis of HIV or AIDS diagnosis, is prohibited. E.g., see UN Commission on Human Rights, Resolutions 1995/44 (3 March 1995), 1996/43 (19 April 1996), and 2004/26 (16 April 2004).

\(^{1246}\) E.g., see UNAIDS/OHCHR, International Guidelines on HIV/AIDS and Human Rights, para. 149. Similar analysis would apply to discrimination against someone based on something like infection with hepatitis B or C virus (HBV, HCV) or on the basis of a sexually transmitted infection. Given modes of transmission, many people who inject drugs are vulnerable to infection with other blood-borne diseases such as HBV or HCV, in addition to HIV, and may face discrimination on that basis, as has been observed in other jurisdictions. In making amendments to strengthen protection against HIV-related discrimination in an area such as employment or educational contexts, it would be advisable to explicitly include protection against discrimination based on such other diseases.
requiring drug testing before employment is unjustified discrimination based on health condition. Requiring testing for drug use during employment may only be potentially justifiable in quite limited circumstances, such as limiting testing to positions that are safety-sensitive and then only in cases where there are reasonable grounds to suspect impairment or possibly random drug testing of persons returning to work after receiving treatment for drug dependence.

- It is recommended to begin a consultation process with policy-makers and to study experiences of other countries for models of legislation that limits restrictions on permitted occupations based on drug use only in specific cases defined in the law and based on individual assessments of ability to perform.

- Provisions in the Law on narcotics and in the national anti-drug programme that encourage or permit workplace drug testing in overly broad circumstances should be eliminated.

- Instead, it is recommended that the law (perhaps the Law on narcotics) be amended to include a provision along the lines of the following:  

  **Discrimination based on drug use**

  (1) Absent a reasonable justification given the circumstances of the case, it is prohibited to discriminate against a person, or a relative or associate of the person, on the ground that the person uses or has used drugs, or is perceived to use or have used drugs.

  (2) It is unlawful discrimination to require that a person undergo drug testing as condition of enrolment in an educational institution, either before or during enrolment.

  (3) It is unlawful discrimination to require that a person undergo drug testing as a pre-condition of employment. Making drug testing a condition of continued employment is permitted only in positions, as designated by [suitable government authority], where impairment while at work may pose a significant risk of harm to the individual employee or to others and where there are reasonable grounds to suspect that the individual employee may be impaired by drug use.

---

**Recommendation 28: Respect and protect family relationships**

As noted above, current law states that in the case of concern about child abuse or neglect, drug or alcohol dependence can per se be a basis for deprivation of parental rights (custody of a child). This risks discriminating against people based on a health condition, rather than ensuring careful regard for individual circumstances; which would not be justified. Thus, Article 70 of the Code of Marriage and Family should be amended to clarify that, in cases of concern about child abuse or neglect, drug dependence should not be assumed to be per se sufficient grounds to deprive someone of parental rights, but rather than a careful analysis of the individual circumstances is required, governed by the over-riding consideration of the best interests of the child.

**Recommendation 29: Eliminate discrimination in voting rights**

Currently, prisoners and persons in preventive detention are denied the right to vote under various decrees. International law recognizes that prisoners retain all human rights except those necessarily limited by the fact of incarceration. Denying the right to participate in elections does not meet this test. These prohibitions should be repealed.

---


1248 Code on Marriage and Family of Turkmenistan, Article 70.
Recommendation 30: Avoid overly broad application of criminal law regarding HIV/STI transmission

It is recommended to repeal Article 117 of the Criminal Code, which criminalizes knowing STI transmission, and Article 11 of the Criminal Code, which criminalizes exposure and transmission of “the AIDS disease” ("knowing exposure to AIDS"). Any use of the criminal law to deal with HIV transmission should follow the guidance issued by UNAIDS in applying the law to fairly narrow circumstances.

Recommendation 31: Abolish legislative discrimination based on sexual orientation

Under current law, consensual sex between adult men remains a crime (Criminal Code, Article 135). As noted above, this discrimination contravenes international human rights law, including rights to non-discrimination and privacy, and is counter-productive in that it undermines HIV prevention efforts and access to health information and services among men who have sex with men. The national expert group has recommended initiating discussions for the purpose of abolishing of the criminal liability for consensual homosexual activity between adults. To achieve this, Article 135 of the Criminal Code should be repealed.

Recommendation 32: Enact reforms to protect the health and safety of sex workers

Currently, the law imposes administrative and criminal liability for prostitution and related activities. Such measures do not prevent or eliminate prostitution, but rather contribute to the lack of safety of sex workers and create barriers to protecting and promoting the health of sex workers, including through programmes and services to prevent and treat HIV and other STIs. Violence and abuse of sex workers are critically important human rights issues, and adequately enforcing existing laws against such abuses should be a priority, rather than imposing penalties on sex workers. It is recommended to begin discussions with the objective of abolishing such administrative or criminal liability for prostitution and for a range of related activities. To achieve this objective, the Government should abolish both administrative and criminal law provisions regarding prostitution: Articles 176(1) and 176(2) of the Administrative Offences Code, and Article 138 of the Criminal Code.

1249 Criminal Code, Article 119.
UZBEKISTAN

SUMMARY REPORT AND RECOMMENDATIONS
UZBEKISTAN: SUMMARY REPORT AND RECOMMENDATIONS

1. BACKGROUND

With a population of more than 27 million people, Uzbekistan is the most densely populated country in Central Asia. Like other countries of Central Asia, Uzbekistan faces an increasing drug use problem. In 2008, the total number of people using drugs and registered as such for medical surveillance and prevention purposes was an estimated 21,439 people; 85.6% of them were opioid injectors and 16.4% were cannabis users. Women accounted for approximately 4-5% of the total number of people registered.

In recent years, the number of people living with HIV has increased dramatically: there were 154 new HIV infections recorded in 2000, while in 2008 this figure had increased to 3,404 new infections. Until 1999, HIV was transmitted mostly sexually (98% of all cases), but as of 1999, HIV infections attributed to injection drug use had become predominant (80% of all cases of new infections in 1999, and in 65.9% in 2006). As of 2008, there were 15,831 people infected with HIV in the country, among whom 7,373 (46.6%) were injecting drug users.

---

1253 National informational and analytical centre on Drug control, under the Cabinet of Ministers of Uzbekistan, 2009.
1254 Ibid
1255 Ibid.
1256 Information reported from the National AIDS Centre as of 2006: ibid., pp. 51, 108-109.
2. NATIONAL PROGRAMMES AND STRATEGIES

Programme on HIV/AIDS
There is an Emergency Anti-Epidemics Commission and the Country Coordination Committee (established in connection with a grant received from the Global Fund to Fight AIDS, Tuberculosis and Malaria). These bodies are established under the Cabinet of Ministers of the Republic of Uzbekistan and the Council of Ministers of the Republic of Karakalpakstan (an autonomous republic within the Republic of Uzbekistan). People living with HIV/AIDS are members of the Country Coordination Committee.

The Republic of Uzbekistan has adopted and is implementing the Strategic Programme of Counteraction to HIV-infection in the Republic of Uzbekistan for 2007 – 2011. The Country Coordination Committee is responsible for its implementation and monitoring of activities is carried out based on national indicators in this sphere. Funding for the Strategic Programme is to come from both budget allocations by the Government of Uzbekistan and donor contributions. The national expert group reports that nearly 80% of the programme’s funds are spent on HIV prevention measures. According to the national expert group, implementation of the Programme is intended to involve a wide range of partners and civil society along with representatives of vulnerable populations.

The principles of the Strategic Programme include the following:

- observance of human rights in accordance with national legislation, and the eradication of HIV-related stigma and discrimination;
- creation of a supportive legal and political environment for HIV prevention and treatment activities;
- guarantees of a multi-sectoral approach to address the HIV epidemic;
- large-scale involvement of civil society and people living with HIV in activities relating to HIV prevention;
- guarantees of a comprehensive approach to the reduction of vulnerability through adoption of safer behaviours; and
- guarantees of universal access of the population as a whole, and vulnerable groups specifically, to HIV prevention, treatment and support, including psycho-social and legal protection.

Major elements in the Strategic Programme are:
- improvements to the legal and regulatory framework;
- a single comprehensive system of monitoring and evaluation;
- HIV prevention interventions among at-risk populations and young people;
- activities to prevent mother-to-child transmission of HIV and transmission in health care facilities;
- treatment for sexually transmitted infections (STIs); and
- high-quality treatment for people living with HIV, as well as psychosocial support and care.

According to the Strategic Programme, HIV prevention efforts targeting particular “high-risk groups” include drug demand reduction initiatives and establishing a variety of “trust points” to provide low threshold services, such as distribution of information, condoms and sterile syringes. Currently there is one national AIDS Centre and 14 regional centres.

In December 2008, President of Uzbekistan signed Resolution "On additional measures of increasing effectiveness of HIV prevention in the Republic of Uzbekistan". This Resolution mandates establishment of a modern unified system of addressing HIV/AIDS, consisting of the National and regional AIDS centres. The Resolution created the National Commission on coordination of measures to address HIV prevention, whose mandate includes coordination and partnerships of governmental agencies, ministries, national and local authorities and non-governmental organisations in the area of HIV prevention; development

1257 Strategic Program Against HIV Infection in the Republic of Uzbekistan for 2007 – 2011, [Стратегическая программа противодействия распространению ВИЧ-инфекции в Республике Узбекистан], approved by the Deputy Prime Minister of the Republic of Uzbekistan, Order No 07/10-115 (3 July 2007).
1258 Information is provided by the national expert group.
1259 Information is provided by the national expert group.
and implementation of National Plans on AIDS; monitoring and evaluation of HIV/AIDS response; and research and evaluation of safe and efficient methods of HIV prevention. Among others, the Commission is mandated to develop and oversee measures aimed at elimination of anti-social behaviours that lead to the spread of HIV, preservation and development of spiritual and moral foundations and traditional values of the nation of Uzbekistan, and to conduct of educational activities to this aim.

The 2008 Resolution also adopted National Plan of Action on prevention of spread of HIV-infection in the Republic of Uzbekistan for 2009-2011, which includes HIV prevention measures, building institutional structure of AIDS centres and other health care facilities, ongoing continuing education of health care professional in the sphere of HIV/AIDS; organising educational activities in this area, and cooperation and coordination with international organisations. Within the Programme “On implementation of a national response to HIV/AIDS, with a special focus on vulnerable populations”, correctional facilities have implemented a project on HIV prevention among prisoners since 2006. This project is aimed at presenting detailed information on HIV and prevention measures to prisoners, who in turn will train other prisoners as peer educators. This programme is implemented with the Global Fund to Fight AIDS, Tuberculosis and Malaria funding.

The Republic of Uzbekistan has made welcome declarations that its response to HIV/AIDS will reflect a multi-sectoral approach of coordinated efforts of the entire community, and will reflect transparency and accountability. However, the national expert group has pointed out several problems pertaining to legislation and law enforcement regarding vulnerable populations, which factors impede implementation of HIV prevention and other health programmes. The experts indicate that one such problem is legislative ambiguity which leads to misunderstanding and different interpretation of certain legal and regulatory documents by various state agencies whose policies and programmes have an impact on HIV prevention efforts. (A number of recommendations in the final section of this country report are aimed at addressing this concern.)

Programme on narcotic drugs

The State Commission for Drug Control (under the Cabinet of Ministers of the Republic of Uzbekistan) and regional commissions for drug control are responsible for anti-trafficking activities and preventing drug use in the country. The Prime Minister chairs the State Commission; the head of each regional health care department is a member of the relevant regional commission.

In July 2007, the Government adopted a “Programme of comprehensive measures against drug abuse and drug trafficking for 2007-2010”. Funding for this Programme is allocated “within the limits of annual budget and extra-budgetary resources”. The National Information and Analytical Centre for Drug Control oversees the implementation of the Programme. Important dimensions of this Programme include: ensuring social protection and employment of people with drug dependence; prevention of drug dependence and related offences; and strengthening health care services to people with drug dependence.

This Programme makes explicit provision for harm reduction measures. In particular, section 1(4) provides for “establishing, based on the local situation, a network of anonymous counselling units in order to implement low-threshold rehabilitation and prevention programmes, including harm reduction programmes.” Section 5(2) provides for: increasing the range of services provided by harm reduction programmes (e.g., psychological counselling support); strengthening and establishing “trust points” for injection drug users; and developing a system of training workshops for people who use drugs to become peer educators.

Since 2004, the AIDS Foundation East West (AFEW) has implemented a programme that includes a component on “Reduction of drug demand and health care in prisons". In February 2005, the Chief of the Correctional Department of Uzbekistan [главное управление исполнения наказаний] issued an order “On establishing a Working group on implementation of a drug demand programme, and health protection in the penitentiary system of Uzbekistan”, under which workshops, trainings and information sessions are carried out to increase prisoners’ awareness of the harms connected with drug use and methods of preventing HIV, viral hepatitis and tuberculosis.

1261 Program of comprehensive measures against drug abuse and drug trafficking for 2007-2010, [Программа комплексных мер противодействия злоупотреблению наркотиками и их незаконному обороту на 2007-2010], No. 8/07 (2 May 2007).

1262 See more about AFEW’s “Drug Demand Reduction Program in Uzbekistan, Tajikistan and in the Fergana region of Kyrgyzstan” at http://www.afew.org/russian/projects_sw_uz.php [программа снижения спроса на наркотики].
3. ADMINISTRATIVE AND CRIMINAL LAW PROVISIONS ON NARCOTIC DRUGS

For purposes of determining administrative or criminal liability for drug offences, amounts of narcotic and psychotropic substances are divided into “small” [небольшие], “exceeding small” [превышающие небольшие] and “large” [крупные] quantities. Applying these categories is within the authority of investigative bodies and courts, based on a list determined by the State Commission on Drug Control.¹²⁶³ ¹²⁶⁴

Uzbekistan does not have either criminal or administrative liability for the mere use of narcotic substances or for possession of paraphernalia for drug use (e.g., syringes, disinfectants and other equipment).

**Administrative offences**

According to the provisions of the *Code of Uzbekistan on Administrative Liability* (hereinafter "Administrative Code"), illegal production, acquisition, possession, transportation or mailing of narcotic or psychotropic substances in “small” [небольшие] quantities are administrative offences without intention to sell.¹²⁶⁵ The minimum age of administrative liability is 16.¹²⁶⁶

**Criminal offences**

Offences involving “exceeding small” [превышающие небольшие] and "large" [крупные] quantities of controlled substances are criminal offences. The *Criminal Code of Uzbekistan* distinguishes between possession of drugs with or without intention to sell. The *Criminal Code* makes the following criminal offences:

- illicit production, acquisition, possession and other activities related to narcotic drugs and psychotropic substances *without intent to sell* are punishable by a fine or correctional labour for up to 3 years, arrest for up to six months or imprisonment for up to 3 years;¹²⁶⁷
- illicit production, acquisition, possession and other actions with narcotic drugs or psychotropic substances with *intention to sell*, as well as actual *sale*, are punishable by imprisonment from 3 to 5 years; illicit sale of narcotic drugs or psychotropic substances in large quantities is punishable by imprisonment from 19 to 20 years.¹²⁶⁸
- "involvement" [вовлечение] in the use of narcotic or psychotropic substances is punishable by corrective labour for up to 3 years or imprisonment for up to 3 years;¹²⁶⁹
- cultivation of illegal substances is punishable by a fine or correctional labour for up to 3 years or imprisonment for up to 3 years;¹²⁷⁰
- violation of the rules of production and other handling (e.g., importation/exportation, distribution) of narcotic drugs and psychotropic substances is punishable by a fine, deprivation of the right to hold certain posts and professions for up to 5 years, or correctional labour for up to 3 years, or imprisonment for up to 5 years;¹²⁷¹ and
- illegal acquisition of narcotic drugs and psychotropic substances is punishable with correctional labour for up to 3 years or imprisonment for up to 5 years.¹²⁷²

---

¹²⁶³ State Commission of Uzbekistan on Drug Control, “List of narcotic drugs determining small, exceeding small and large quantities when detected in illegal possession or trafficking” [Перечень наркотических средств с отнесением их количества к небольшим, превышающим небольшие и крупным размерам при обнаружении в незаконном владении и обороте], Decision No. 3 (22 May 1998).

¹²⁶⁴ In Uzbekistan, there are three lists setting out varying degrees of legal control over activities related to controlled substances, such as exportation, importation, production and distribution. List I consists of substances for which all such activities are prohibited. List II substances are those for which such activities are strictly controlled. List III consists of substances for which such activities are limited to lesser extent. These lists are set out in Resolution No. 293 (31 July 2000) adopted by the Cabinet of Ministers.

¹²⁶⁵ *Code of the Republic of Uzbekistan on Administrative Liability*, [Кодекс Республики Узбекистан об административной ответственности], Law No. 2015-XII (22 September 1994), Article 56 ["Administrative Code"].


¹²⁶⁹ *Criminal Code*, Article 274.

¹²⁷⁰ *Criminal Code*, Article 270.

¹²⁷¹ *Criminal Code*, Article 275.

¹²⁷² *Criminal Code*, Article 272.
Penalties for the offence of illegal distribution (i.e., trafficking) increase for repeated offences. The Crimi-
nal Code does not provide for the confiscation of other property as a penalty for a criminal offence, but illegal drugs and drug-production equipment are confiscated. Being under the influence of alcohol or drugs while committing an offence is an aggravating circumstance.

Generally, 16 is the minimum age for criminal liability, but for some offences (e.g., illicit acquisition of narcotic drugs by theft or fraud), 14 is the minimum age.

Needle exchange programmes: legal issues
Criminal or administrative liability for possession of residual quantities of narcotic drug in a syringe depends on the type and amount of narcotic substance, according to the above-mentioned lists. The national expert group has pointed out that the law lacks provisions excluding harm reduction measures from possible criminal or administrative liability. The national expert group has noted that outreach workers, peer consultants and other syringe and needle exchange programme staff could theoretically run afoul of these provisions.

Compulsory drug testing by law enforcement authorities
Uzbek law provides several bases on which a person may be subjected to drug testing without his or her consent. One such instance is that police, investigative authorities and courts may order a person to be tested if there are “sufficient reasons to believe” that he or she suffers from drug dependence, is in a state of intoxication, has used a narcotic or psychotropic substance without medical prescription, or is carrying a narcotic or psychotropic substance inside his or her body.

As the national expert group noted, this broad provision for involuntary drug testing could contribute to the further marginalization of people who use drugs and encourage corruption on the part of law enforcement officials. Such wide provisions on compulsory drug testing, vesting such extensive powers in law enforce-
mint bodies, represent not only an inefficient use of limited resources but also an unjustified intrusion on human rights. For example, subjecting someone who has not committed an offence to involuntary drug testing violates the right to liberty, security of the person and privacy, as well as the right to be free from non-consensual medical intervention; if test results are also used against the person in any sort of prosecu-
tion, it would also violate the right against self-incrimination. The only possible bases on which it might be justifiable for the state to infringe such human rights would be to intervene to prevent a serious risk of harm to oneself or to others; mere use of alcohol or drugs does not, by itself, establish this.

The national expert group has suggested that implementation of well thought-out public health laws, instead of criminal law and punishment, often allows for faster achievement of intended goals of protect-
ting and promoting public health. Public health laws may be more flexible, allowing public health personnel to take more private measures tailored to the circumstances of the individual case. Factors underlying HIV risk behaviours — such as drug dependence, lack of information, poverty or violence — can often be resolved more effectively if one does not resort to criminal prosecution. Health care laws also allow taking more balanced steps with regard to ensuring individual freedoms and protection of public health — e.g., by ensuring that people living with HIV receive necessary consultations and access to health care services.

1273 Article 53 of the Criminal Code (confiscation of property) was repealed by legislation passed on 29 August 2001.
1274 Law “On narcotic drugs and psychotropic substances” [О наркотических средствах и психотропных веществах], Law No. 813-I, (19 August 1999), Article 37.
1275 Criminal Code, Article 56.
1276 Criminal Code, Article 271.
1277 Resolution “On judicial practices regarding offences related to trafficking of narcotics drugs and psychotropic substances” [О судебной практике по делам о преступлениях, составляющих незаконный оборот наркотических средств или психотропных веществ], No. 21 (27 October 1995). According to the Resolution, “involvement” in narcotic drug use should be understood as “any deliberate actions aimed at enticing a person to use drugs (persuasion, offers, advice, etc) as well as deception, psychological or physical violence, restriction of freedom, etc, aimed at influencing a person to use drugs.”
Groups at high risk of HIV: criminal and administrative law issues

Sex between adult men

Currently, the Criminal Code makes consensual sex between adult men a crime, with a penalty of imprisonment for up to three years.1280 This contravenes international human rights law, including rights to non-discrimination and privacy, and is counter-productive in that it undermines HIV prevention efforts and access to health information and services among men who have sex with men.1281 The UN Human Rights Committee has ruled that the right to privacy under the International Covenant on Civil and Political Rights (Article 17) is violated by such laws criminalizing consensual sex between adults of the same sex. The Committee has specifically noted that:

...the criminalization of homosexual practices cannot be considered a reasonable means or proportionate measure to achieve the aim of preventing the spread of HIV/AIDS... [B]y driving underground many of the people at risk of infection ... [it] would appear to run counter to the implementation of effective education programmes in respect of the HIV/AIDS prevention.1282

It is recommended that Uzbekistan repeal this discriminatory provision in the Criminal Code.

HIV exposure and transmission

Article 113 of the Criminal Code of Uzbekistan provides for criminal liability for the following:

- "knowingly exposing someone to venereal disease" is punishable by a fine, correctional work for up to one year, or arrest for up to three months;
- transmission of venereal disease by a person who knew of his or her infection is punishable by arrest from three to six months or imprisonment for three to five years;
- knowingly exposing someone to "AIDS disease" and the transmission of "AIDS disease" is punishable by imprisonment from eight to ten years.

Having a specific criminal offence singling out HIV exposure and negligent transmission runs contrary to internationally recommended policy, in part because it stigmatizes people living with HIV and creates a further disincentive for HIV testing and an additional barrier to access to health services. The International Guidelines on HIV/AIDS and Human Rights recommend against such an approach: criminal legislation should not include specific offences regarding HIV transmission or exposure, and the scope of applying criminal law should be limited to those cases where someone acts with malicious intent to transmit HIV and does in fact transmit the virus.1283

Criminalization of sex workers

Under the Administrative Code (Article 190) sex work is an administrative offence punishable by a fine. The same offence repeated within a year after a first penalty leads to a higher fine. Under the Criminal Code (Article 131), “organising brothels and pimping with the purpose of receiving profit or other immoral reasons” is punishable with a fine or correctional labour for up to three years. However, criminalizing sex workers contributes to their further stigmatization and marginalization, putting them at greater risk of human rights abuses and exacerbating vulnerability to HIV. It is recommended to decriminalise sex work, in compliance with international standards. The International Guidelines on HIV/AIDS and Human Rights recommend that “with regard to adult sex work that involves no victimization, criminal law should be reviewed with the aim of decriminalising and legally regulating occupational health and safety conditions to protect sex workers and their clients, including support for safe sex during sex work”.1284

---

1280 Criminal Code, Article 120.
1284 International Guidelines on HIV/AIDS and Human Rights, Guideline 4, para. 21(c).
4. HEALTH SYSTEM AND SERVICES

The Constitution of the Republic of Uzbekistan guarantees good-quality health care to all citizens. The government has established a guaranteed scope of health care services provided for free at state health care facilities. All health services outside the guaranteed scope of services are paid for privately by patients. Access to health services for migrants and refugees is equal to that of citizens of Uzbekistan. Primary health care services are provided at health care facilities in the district where a patient is registered as a resident. According to the national expert group, drug use cannot constitute a satisfactory reason for denying people treatment for HIV, hepatitis, tuberculosis or drug dependence. Patients living with HIV are eligible to receive anti-retroviral treatment (ART) and, if opioid-dependent, opioid substitution treatment (OST), for free. Such treatment programmes are funded by the Global Fund to Fight AIDS, Tuberculosis and Malaria. However, there is limited access to health services for people who lack a permanent place of residence. At present, one drop-in centre operates in the city of Samarkand under an Uzbek-Swiss project on harm reduction among people who inject drugs.

Free treatment for certain categories of diseases
Uzbek law contains the categories of “socially significant diseases” [социально значимые заболевания] and “diseases that pose a threat to others” [заболевания, представляющие опасность для окружающих], which categories are defined by the Cabinet of Ministers. “Social significant diseases” include: tuberculosis, sexually transmitted infections (STIs), HIV/AIDS, cancers, malignant growths, leprosy and mental disorders (including drug dependence). Free health services are guaranteed by the government to all patients with social diseases. Therefore, all people with social diseases receive medical assistance and free medication at outpatient facilities, and treatment in inpatient facilities. HIV/AIDS and hepatitis are also classified as diseases posing a threat to others; persons suffering from such diseases are also eligible to receive free health services at specialized facilities within the public health care system.

Excerpts from interviews conducted by the national expert group:

“Marat”, 32 years old, uses drugs:

“It is actually pretty easy to receive health care services. One can go to a polyclinic. But I rarely go there. I know that I would need a passport with the certificate of domicile to be admitted to the hospital.

I have undergone [drug dependence treatment] five times. The first time I thought that after treatment I would quit. But they couldn’t help me then. Withdrawal symptoms were so violent that I escaped on the second day. Then, I went for drug dependence treatment in order to reduce the dose. But there is always a shortage of medications at hospitals. The last time was a year ago. The medication situation had improved a little. Treatment at a rehab centre is free, but when there are no medications I need, I have to buy them. [If] you break the rules, they discharge you from the hospital. In general, they don’t keep patients there against their will. Get treatment if you want to, and leave if you don’t. I only know that in case of a compulsory treatment, you have to stay at the hospital for the whole period.

Police and then courts refer people for [compulsory treatment]. There is also compulsory treatment in the penitentiary. But this “treatment” doesn’t work at all. I was told that. Even after routine compulsory treatment [outside of prisons], no one quit. No use. If you don’t want to [quit yourself], it’s all useless. As far as rights go – when the police files for a compulsory treatment order, who would ask about my rights?”

1286 Ibid., Article14: “Foreign citizens on the territory of the Republic of Uzbekistan are guaranteed a right to health protection in accordance with international agreements of the Republic of Uzbekistan. Stateless persons permanently residing in Uzbekistan are provided with the same health services as citizens of the Republic of Uzbekistan. The procedure of rendering medical assistance to these persons is determined by the Ministry of Health of the Republic of Uzbekistan.”
1287 The list of social diseases was approved by the Cabinet of Ministers of the Republic of Uzbekistan: Resolution “On approving the list of social diseases and establishing privileges for people suffering from them” [Об утверждении перечня социально значимых заболеваний и установлении льгот лицам, страдающим ими], Resolution No. 153 (20 March 1997).
1288 The list was adopted by the Cabinet of Ministers of the Republic of Uzbekistan, Order No. 96 (20 February 1997).
I am now on a waiting list for methadone, four months already. I am waiting for a vacant space, for my turn for substitution treatment. I know four drug addicts who go there and get pills. They're happy. The most important this is they don't go looking for drugs. They work. One of them got married. It's hard to get the ST – long waiting list. It's a pity they only offer it at the narcological facility.

[Answering a question about what needs to be changed to improve access to health care services and HIV prevention and treatment for drug users] Probably, there is no need for registration of drug users. There is no use of it anyway. Those who use drugs, use them anyway. Those who want treatment, go for treatment. I think substitution treatment should be extended¨.

Sex worker, name withheld

[Answering a question about receiving health care services]: Theoretically, there is a chance, I can go to a polyclinic. Going to an STI clinic...is problematic. It is better to do it unofficially, go to doctors you know – there will be no publicity.

[Answering a question about denial of health care]: Yes, there were cases when I was denied [health care], time and again. The reason: I have no certificate of domicile at the place where I live. I have my own gynecologist, I pay money, get information and treatment if I need to.

[Answering a question about what needs to be changed to improve access to health care services and HIV prevention and treatment]: There is a need to increase anonymous rooms at STI and gynecological facilities. Generally, stop persecuting us. Our work should be made legal.

4A. DRUG DEPENDENCE PREVENTION AND TREATMENT

Under the Law “On narcotics drugs and psychotropic substances”,1289 the government guarantees people with drug dependence narcological assistance including health examinations, counselling, diagnostics, treatment and medical and social rehabilitation services. In accordance with the law, narcological assistance to patients with drug dependence is provided at their request or with their consent, while minors at the age younger than fourteen years are treated at the request or with the consent of their parents or other legal guardians. People with drug dependence who voluntarily seek drug dependence treatment are guaranteed confidentiality of treatment at their request.1290 The Ministry of Health has adopted standards of narcological assistance, described by the national expert group as being based on comprehensive, step-by-step, and differential approach to treatment including modern methods of examination and treatment.1291

However, as recommended by the national expert group, given the growing problem of drug dependence, a special law supporting prevention and treatment of drug dependence is advisable. Currently, the Law “On narcotics drugs and psychotropic substances” contains only three articles which govern drug dependence treatment, and this legislation is largely aimed at prohibiting various drug-related activities, rather than a health-based response. Creating a separate legislative framework, with clear responsibility for the Ministry of Health in preventing and treating drug dependence would be helpful, as it would counteract what remains a dominant focus on criminalizing people who use drugs. In this regard, the Ministry of Health has developed a suggestion to the Cabinet of Ministers about developing and adopting a new Law “On narcological assistance”. The adoption of such a law has been included in the list of activities approved by the State Commission on Drug Control.1292

1289 Law “On narcotic drugs and psychotropic substances”, Article 44.
1290 Ibid.
1291 Ministry of Health, Order “On Approving Standards of Diagnosis and Treatment of Patients with Drug Dependence” (Об утверждении стандартов диагностики и лечения наркологических больных), Order No.19 (15 January 2004).
1292 State Commission on Drug Control, Resolution “On the Program of comprehensive measures to counteract illicit drug abuse and trafficking for 2007-2010”, Resolution No. 8/07 (2 May 2007).
Registration of people who use drugs

As is common in the region, Uzbekistan maintains a system of registration of persons with drug dependence and persons who use drugs.\(^{1293}\) Registration and deregistration is done by territorial narcological facilities based on the decision of a health advisory board. A person may be removed from the registry, based on a decision of a health advisory board, in the following situations:

- three years’ “remission” (i.e., no drug use);
- sentence to imprisonment for more than one year;
- lack of information about a patient for more than one year; or
- death of the patient.

The registry is maintained by territorial narcological facilities and law enforcement agencies. The national expert group has noted that medical facilities report information about persons who are registered to law enforcement agencies, including cases in which people seek overdose treatment. This sharing of patient information is based on a joint order from the Ministries of Health and Internal Affairs.\(^{1294}\)

The fear of negative consequences flowing from being registered as a drug user will, for some people, create a further barrier to seeking drug dependence treatment. Such consequences include the loss of confidentiality, discrimination (as some rights of people who use drugs are restricted by law as described further below, or greater exposure to police attention and possible criminal prosecution in future. Seeking health services should not come with these consequences; this undermines efforts to protect and promote the health of some of those most vulnerable, including reducing the risk of infection with HIV and other blood-borne diseases associated with risky drug use practices. It is recommended to abolish the practice of drug user registration and the practice of reporting to law enforcement agencies registered persons who seek medical assistance, including in cases of overdose.

Compulsory drug dependence treatment

Uzbek law maintains that, as a general rule, voluntary, informed consent is a prerequisite for any medical intervention.\(^{1295}\)

However, as noted above in Section 3, compulsory drug testing may be imposed by law enforcement authorities in a number of circumstances. In addition, according to the national expert group, compulsory testing is also performed in cases where it is necessary to decide on imposing compulsory drug dependence treatment in specialized health care facilities or in prisons.

In Uzbekistan, compulsory drug dependence treatment may be imposed by court order in two circumstances.\(^{1296}\)

First, a court may order compulsory treatment for drug dependence in the case where a person with drug dependence, as established by medical evidence, has committed a crime. This compulsory treatment will be ordered in addition to the criminal sentence imposed.\(^{1297}\) If the sentence consists of a penalty other than imprisonment, the person undergoes compulsory treatment at health facilities. If the sentence includes a penalty other than imprisonment, the person undergoes compulsory treatment at health facilities. If the sentence includes a penalty other than imprisonment, the person undergoes compulsory treatment at health facilities.

\(^{1293}\) Article 46 of the Law “On narcotic drugs and psychotropic substances” provides the statutory basis for the regulations governing drug user registration in Uzbekistan. Registration is done in accordance with the Order of the Ministry of Health “On Approving the Instruction for Registration and Surveillance of Persons Allowing Non-medical Consumption of Narcotic and Psychotropic Substances, Persons with Drug or Substance Dependence” (Об утверждении инструкции о порядке взятия на учет и наблюдения за лицами, допускающими немедицинское потребление наркотических средств и психотропных веществ, больными наркоманией и токсикоманией), Order No. 1494 (15 July 2005).

\(^{1294}\) Ministry of Internal Affairs/Ministry of Health, Joint Order “On Approving the Instruction for the Procedure of Organizing Prevention Activities of Internal Affairs and Health Care Agencies with Persons Abusing Alcoholic Drinks or Narcotic Substances and Referrals to Obligatory Treatment of People with Chronic Alcoholism and Drug Dependence” (Об утверждении инструкции о порядке организации профилактической работы органов внутренних дел и здравоохранения с лицами, злоупотребляющими спиртными напитками или наркотическими средствами, и направления на принудительное лечение больных хроническим алкоголизмом или наркоманией ), Order No. 326/599 (27 December 1994).

\(^{1295}\) Law “On health protection”; Article 24. In emergency situations where a patient is not capable of expressing his or her will, a council of physicians makes the necessary decisions about medical intervention. According to the national expert group, if a person refuses medical assistance, the possible consequences of that refusal are supposed to be explained, with this confirmed by a written record in the person’s medical file that is signed by the health worker and the patient and certified by witnesses.

\(^{1296}\) Law “On compulsory treatment of persons with chronic alcohol, drug or other substance dependence” (О принудительном лечении больных хроническим алкоголизмом, наркоманией или токсикоманией), Law No. 753-xii (9 December 1992), with amendments by Law No. 175-II (15 December 2000), Regulation No. 73-I of the Supreme Council of Uzbekistan (6 May 1995), Regulation No. 371-I of the Supreme Council (27 December 1996), Law No. 550-I (26 December 1997), and Regulation No. 714-I (24 December 1998).

\(^{1297}\) Criminal Code, Article 96.
cludes imprisonment or other custodial penalty, the drug dependence treatment will be imposed in the custodial setting; if, upon discharge from prison, further treatment is ordered, that treatment will take place in health facilities.

It should be noted that international drug control treaties explicitly allow States Parties to include, in their domestic legislation, alternatives to conviction and incarceration for drug offences, including providing treatment and rehabilitation services, instead of adding these on top of criminal sentences. There appears, therefore, to be room for Uzbekistan to change its current legislative approach of imposing compulsory treatment in addition to other criminal punishment.

Second, compulsory treatment may also be prescribed in cases where a patient with drug dependence disturbs the public peace, violates the rights of other people or “poses a threat to the safety, health or morals of the population”. Such a court order is made based on documented medical evidence and upon the request of either Internal Affairs agencies or a petition by family members or relatives of the patient, by co-workers or by health care personnel. A person ordered to undergo drug dependence treatment can appeal the order, as can a prosecutor. If the patient does not appear for treatment as ordered, without a plausible reason, he or she is subject to arrest by law enforcement agencies. A committee of the health facility providing treatment determines whether to continue or discontinue compulsory treatment.

International organizations underline the principle that drug dependence treatment should generally be voluntary. As a general proposition, compulsory medical treatment violates human rights, including to liberty, security of the person and privacy, and should be applied only in extreme, clearly defined cases with a view to preventing a person from causing imminent, serious harm to himself or herself or to others. There appears to be a need to tighten current Uzbek law to circumscribe more narrowly the bases on which compulsory treatment may be imposed.

**Opioid substitution treatment**

From 2004 to 2009, Uzbekistan offered opioid substitution treatment (OST), in the form of both methadone and buprenorphine, under a regulation adopted by the State Commission for Drug Control. Until 2008, OST was provided through one pilot project at the Tashkent City narcological facility. According to reports, in 2008, the Ministry of Health had been considering expanding OST projects in two more regions of the country (Samarkand and Bukhara), but instead in 2009 discontinued all existing pilot projects.

Apart from the above Regulation, the legal basis for OST was provided for in the Law “On narcotic drugs and psychotropic substances”, which states that “means and methods that are not prohibited by the Ministry of Health of the Republic of Uzbekistan are used for drug dependence treatment.” The selection of patients for substitution treatment was done by a special Advisory Committee, whose composition was approved by the head physician of the narcological dispensary. The duration of OST was not limited and was defined individually upon agreement with the patient. Under the OST pilot project, both detoxification and short-term and long-term substitution treatment were provided. Patients participated in discussion of treatment and choice of doses. Substitution medications were not dispensed to take home, and any decision to discontinue OST was adopted only by the advisory board. During outpatient substitution treatment, patients were tested for the use of illicit drugs and psychoactive substances to determine if the patient used other drugs. If patient used other drugs, substitution treatment was discontinued and the patient dismissed from the programme.

---

1298 Single Convention on Narcotic Drugs, 1961, UN, 520 UNTS 331, as amended by the 1972 Protocol, Article 36(2); Convention on Psychotropic Substances, 1971, UN, 1019 UNTS 175, Article 22; Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances, 1988, Article 3(4).
1304 Law “On narcotic drugs and psychotropic substances”, Article 45.
The discontinuation of OST projects in Uzbekistan is a very disturbing and disappointing development. This decision of the government is contrary to international obligations of the Republic of Uzbekistan to guarantee the highest attainable right to health to its people. It runs contrary to the best international practices of harm reduction, including HIV prevention and effective drug dependence treatment. This decision leaves hundreds of patients without necessary treatment, and at risk of returning to illicit drug use, at risk to be arrested, detained, convicted and imprisoned for drug use (on the basis of their health status). The government of Uzbekistan is recommended to reinstitute the OST programmes immediately, and adopt rigorous quality monitoring and evaluation of these programmes.

Overdose prevention
At present, the response to cases of overdose consists of detoxification treatment and the management of symptoms. Naloxone, an opioid antagonist medication used to counter the effects of opioid overdose (including suppression of the central nervous and respiratory systems), is listed by the WHO as an essential medication for treating poisonings. In 2009 Uzbekistan included naloxone on the list of essential medicines, which means that it will be procured by the government. This is a welcome development which will make naloxone more accessible to people who need it. However, there is more than could be done – according to international recommendations, naloxone should be made available to people who use drugs, their friends and relatives (not only through health care workers). This will reduce instances of death as a result of overdose.

4B. HIV PREVENTION AND TREATMENT

HIV prevention among people who use drugs
There are more than 230 “trust points” in Uzbekistan for HIV and STI prevention among “vulnerable groups”. Trust points provide information and education, counselling, condoms, disinfectants and syringe and needle exchange, in addition to coordinating outreach activities with vulnerable populations. Trust points function at the AIDS centres and at some other health care facilities. The programmes were initially funded by the government; since 2005, they have been funded by the Global Fund to Fight AIDS, Tuberculosis and Malaria. According to the national expert group, trust points respect the principles of confidentiality and anonymity; records are kept using coding systems.

The collection and disposal of syringes and needles, as well as the involvement in trust points’ work of people who use or have used drugs, are regulated by guidelines approved by the Head State Sanitary Physician of the Republic. Trust points train people who use drugs to work as volunteer peer outreach workers. According to the national guidelines, outreach workers:

- establish and maintain contact with people who use drugs;
- collect information about drugs used and problems of people who use them;
- provide advice on where to get health care assistance or undergo anonymous HIV testing;
- refer people to other services, such as drug dependence treatment facilities;
- provide information on how to reduce the risks of harm associated with drug use (e.g., less risky injection practices, overdose prevention) and on safer sex;
- discuss risky behaviours with members of the target group; and
- provide information materials, education and the means of protection.

The national expert group has indicated that trust points’ “low-threshold” services to injection drug users are insufficiently integrated into the network of drug dependence treatment facilities, which mainly aim at full abstinence. Additionally, some trust points are located in inconvenient places and have no separate entrance, and their hours of operation are not always convenient for the intended population. Some trust
points do not have separate staff, and their functions are imposed on physicians as additional tasks. The national expert group has identified these as issues of concern that should be addressed.

**HIV testing**

Uzbekistan has a specific Law “On prevention of disease caused by a human immunodeficiency virus (HIV-infection)” (hereinafter the Law “On HIV”). This short statute consists of 13 articles and regulates the rights of patients and HIV testing procedures, as well as establishing liability for HIV transmission (punishment for which is determined in the Criminal Code). According to this law, citizens of Uzbekistan, as well as foreign nationals and stateless persons in the country, are entitled to voluntary, anonymous HIV testing with guaranteed confidentiality. Regulations approved by the Head State Physician of the Republic ensure patients’ rights to anonymity and confidentiality of testing and medical secrecy as well as the accessibility of testing, and guarantee pre- and post-test counseling.

Pre- and post-test counselling is delivered by health workers, staff of trust points that provide harm reduction services, outreach workers, psychologists and peer consultants. HIV testing is only done at state AIDS centres. The results of HIV tests are filed in a special form with identification, passport data, address, date of testing and the test results. All this information is entered in a database of people with HIV. The national expert group has noted that, in order to maintain confidentiality, information is sent to public health authorities with the stamp “for official use only”. The database may be accessed by specialists engaged in prevention, surveillance, and treatment of HIV.

According to the national expert group, there is a need to further improve HIV testing systems in the country, by making changes to existing legal and regulatory documents of the Ministry of Health. According to the experts, it is necessary to improve the quality of diagnosis, including introducing third and fourth generation testing technology that would considerably decrease a number of false positive results.

**Compulsory or mandatory testing for HIV and other diseases**

According to the national expert group, HIV testing is mostly voluntary. However, the legal and practical reality includes testing that is either mandatory or compulsory in various instances, both of which raise human rights and public health concerns.

Justifiably, HIV testing is mandatory in Uzbekistan for those donating blood. However, HIV testing is also mandatory for foreigners seeking to enter Uzbekistan: in order to obtain a visa to enter Uzbekistan, foreigners must present a certificate confirming HIV-negative status. Foreigners within Uzbekistan who test HIV-positive (as a result of voluntary testing) may be deported. The deportation procedure is not regulated by law; however, the practice is for territorial health bodies to submit the information to the Ministry of Foreign Affairs, which arranges the deportation. However, prohibiting the entry of, or deporting, foreigners with HIV is not supported by international guidelines.

The law of Uzbekistan also mandates testing before marriage for HIV, STIs, tuberculosis and drug dependence. If testing determines that one or both parties planning to marry have one or more of the above conditions, registration of marriage is done after confirming awareness of both parties about the results of these tests. If testing reveals a condition that requires immediate treatment, the person is referred to treatment facilities.


1310 Law “On HIV”, Article 3.


1312 Sanitary Rules.


1314 Ibid., Article 6.


1316 Regulation “On Medical Testing of Persons Planning to Marry” [О медицинском обследовании лиц, вступающих в брак], Regulation No. 365, Annex 1 to the Resolution of the Cabinet of Ministers, “On Approving the Provision of Medical Testing of Persons Planning to Marry” (25 August 2003). Paragraph 4 indicates that persons entering marriage must undergo medical testing for psychological, narcological and venereal diseases, as well as tuberculosis and HIV/AIDS.
HIV testing is also effectively compulsory in some instances. Uzbek law makes it an administrative offence for a person to avoid testing for HIV or STIs if there is "sufficient information" [достаточные данные] to believe he or she is infected, as well as for a person to refuse to disclose the source of infection with HIV or an STI.\footnote{Administrative Code, Articles 57 and 58.} Regulations also require HIV testing of people identified as sexual contacts of persons living with HIV.\footnote{Sanitary Rules.} In addition, compulsory HIV testing may be conducted when requested by police.\footnote{Ibid., para. 13.} Such widespread imposition of HIV testing without consent is not justifiable or necessary. The national expert group has reported that, based on interviews it conducted as part of the assessment, involuntary testing is often imposed on sex workers and people who use drugs,\footnote{See Report of the Republic of Uzbekistan, pp. 44.} a practice which is further contrary to international standards.\footnote{Ibid., Article 45.}

A number of these articles and practices contradict the right to voluntary medical examination for HIV infection, and the Constitution and other legislation of Uzbekistan. In addition, according to international standards, an HIV test should be done on a voluntary basis only, except for obligatory tests for donors of blood and organs.\footnote{Siracusa Principles on the Limitation and Derogation Provisions in the International Covenant on Civil and Political Rights, UN Doc. E/CN.4/1985/4, Annex (1985).} If HIV testing is ever to be imposed without consent, then it requires a process clearly set out in law, with a requirement that such measures be taken only in exceptional circumstances and with adequate justification that must be considered by an independent, judicial body, and with the most limited infringement of human rights possible.\footnote{UNAIDS/WHO Policy Statement on HIV Testing and Counselling, 2006 Consolidated Version, para. 22(j).} In addition, the national expert group has expressed concern that involuntary HIV testing risks driving "at risk" groups underground and creating additional barriers to effective HIV prevention and treatment.

**HIV treatment**

HIV treatment is carried out on the basis of an Order adopted in 2007 by the Ministry of Health, which established major strategic goals and directions in diagnosis, treatment, care and support for persons with HIV.\footnote{Law “On HIV”, Article 4.}

This Order mandated implementation of WHO HIV protocols adapted to the situation in Uzbekistan, voluntary counselling and testing, provider-initiated counselling and testing. Following this Order the system of HIV-labs was restructured; developed a comprehensive plan of carrying out express-tests, in particular in maternity wards, STI clinics, TB dispensaries, drug dependence treatment clinics, “friendly cabinets” and “trust points”. The Order established a system for monitoring of prescription and dispensation of ART-therapy, registry of people with HIV in infectious diseases database; the system of continuous dispensation of ART-therapy is developed on the basis of AIDS centres and other health care facilities, psychological counselling and assistance is provided.

**Patients’ rights, including confidentiality**

The right to qualified health care assistance is provided for in the Law “On protection of public health”, in accordance with which patients have the right to be accorded respectful and humane treatment by health and service staff and the right to give voluntary consent to, or decline, medical intervention.\footnote{Law “On protection of public health”, Article 24 (1).}

In addition, this law provides that information about the fact of seeking medical assistance, health status of a person, diagnosis and other information obtained during testing and treatment, constitute “medical secrets” which must be kept confidential.\footnote{Ibid., Article 45.} The Law “On HIV” also states that the government guarantees the safety, confidentiality and anonymity of HIV testing.\footnote{Law “On HIV”, Article 4.} Breaching the obligation of medical secrecy in Uzbekistan leads to administrative liability.\footnote{Under Article 46 of the Administrative Code, disclosure of a patient’s confidential information and other similar information that may possibly cause moral or material damage to a citizen and his or her rights, freedoms and legal interests, is punishable by a fine.}
In the event that a patient feels his or her rights have been violated, the patient may file a complaint with the manager or another official at the health care facility, a higher management body, or directly with the court. Where a violation of rights is found to have caused harm to the health of a person, the guilty party (individual person or organization/facility) is legally liable and must compensate the victim for damages in accordance with the legislation. In this case, compensation for such damage does not exempt health care staff from additional disciplinary, administrative or criminal liability in accordance with the law.

However, as the national expert group has noted, the anonymity and confidentiality of HIV testing is infringed by other articles in the Law “On protection of public health” and the Administrative Code. While the former “guarantees” anonymity and confidentiality of a patient, at the same time it also states that sharing of medical information is allowed without a patient’s consent:

(1) if there is a threat of spreading infectious diseases (including HIV), poisoning or harm to a large number of people; or
(2) in response to an inquiry from investigative bodies, a prosecutor’s office or a court in relation to an investigation or court proceeding.

Since the Administrative Code makes it an administrative offence for a person to avoid testing if there is sufficient information [достаточные данные] that he or she might have HIV, and this provision of the Law “On protection of public health” allows disclosure of a person’s HIV status without consent when there is a perceived threat of HIV transmission, in practice the law provides for potentially very significant exceptions to the legal “guarantees” of confidentiality. Furthermore, disclosing confidential health information to law enforcement authorities upon request, particularly if that information can be used for administrative or criminal prosecutions or in other ways that infringe upon liberty, security of the person or privacy, is an obvious disincentive for people to seek health services, particularly in relation to such sensitive and stigmatized health conditions as HIV, STIs or drug dependence.

Additionally, in order to better guarantee protection of patients rights, the expert group recommends to develop and adopt a law “On health care activity and patients’ rights” which would fully incorporate international principles related to patient’s rights.

1329 Law “On protection of public health”, Article 24(2).
1330 Ibid., Article 46.
1331 Ibid., Article 45.
1332 Administrative Code, Article 58.
5. PRISONS

As of August 2006, the national prison administration estimated that there were some 48,000 prisoners in custodial facilities in Uzbekistan. Of the total number of prisoners, 21.4% of them are imprisoned for drug-related crimes: 24.2% of these prisoners serve their terms in colony settlements, 33.9% in colonies with a “standard security” regime, 20.8% in colonies with a “strict security” regime, 9.3% in colonies with a “mixed” security regime, 4.6% in “special” regime colonies, 6.9% in colonies providing treatment, and 0.05% in prisons. According to the information presented by the experts, during the last years, following reforms of the penitentiary system, the prison population in Uzbekistan has been decreasing.

Uzbekistan’s penal system operates under the Ministry of Internal Affairs. The national expert group indicates that working groups on HIV prevention in the penitentiary are mandated to ensure implementation of the strategic programme on HIV prevention in correctional facilities. In 2005, the Main Penal Directorate of the Ministry of Internal Affairs issued a decree establishing a working group on drug demand reduction and health protection in the penal system, which group included AIDS Centre specialists, staff of the Main Penal Directorate and the Health Department of the Ministry of Internal Affairs and NGO representatives.

In the penal system of Uzbekistan, the national budget is supposed to cover the costs of providing health care services to prisoners, as well as their food, clothes, and personal hygiene effects. However, as the national expert group has noted, laundry soap is the only personal hygiene item that is provided to prisoners free of charge. Prisoners must purchase all other personal care items, including soap, toothpaste, razors, combs and towels. The experts have noted that this lack of essential items impedes efforts to prevent the spread of infectious diseases, including HIV and hepatitis C, among prisoners, and contradicts the Penal Code “guarantee” that the state pays for health and sanitary services to prisoners.

Pre-trial detainees and prisoners with HIV are not segregated based on HIV status. According to the national expert group, they have the same opportunities to participate in educational, labour, professional and other programmes as other prisoners, and have access to the whole range of available counselling and additional services provided at prisons.

**HIV testing and treatment in prisons**

According to the Ministries of Health and Internal Affairs, HIV testing in penal institutions is conducted voluntarily, accompanied by pre- and post-test counselling. The administrative and health care staff of these institutions must keep confidential information on persons with HIV infection or AIDS. In each pre-trial detention centre and penal institution the head of the facility assigns a health care worker responsible for voluntary testing, pre- and post-test counselling, and registration and follow-up of people living with HIV and AIDS. As a rule, on arrival at a pre-trial detention or penal facility, a doctor (or nurse)

---


1334 People who committed less serious offences as a result of negligence and offences that do not pose a serious social threat are sentenced to colony settlements; persons who committed serious and especially serious crimes for the first time serve their sentence in standard security regime colonies; maximum regime colonies house repeat offenders and those sentenced for intentional, premeditated crimes; special regime colonies house male prisoners considered to be especially dangerous recidivists and sentenced to life imprisonment; persons sentenced to prison terms serve in prisons (cell type penitentiary institutions, with more restriction to movement than in the colony).

1335 Main Penal Directorate (Ministry of Internal Affairs), Decree “On the establishment of the Working Group to implement the drug demand reduction and health protection program in the penal system of the Republic of Uzbekistan” [Приказ Главного управления исполнения наказаний МВД РУ «О создании Рабочей группы по реализации программы снижения спроса на наркотики и охраны здоровья в системе исполнения наказаний Республики Узбекистан»], Decree No. 13 (25 February 2005).

1336 Penal Code of the Republic of Uzbekistan [Уголовно-исполнительный кодекс], Law No. 409-1 (25 April 1997), Article 87 [hereinafter “Penal Code”].

1337 Ministry of Internal Affairs, “Internal regulations of penal institutions” [Правила внутреннего распорядка учреждений по исполнению наказаний в виде лишения свободы], Order No. 118 (8 May 2001), para. 109.

1338 Ministry of Health and Ministry of Internal Affairs, Joint Resolution “On approval of the Regulations for registration and dispensary observation procedures for people with HIV and AIDS detained at pre-trial centres and penal institutions of the Ministry of Internal Affairs of the Republic of Uzbekistan” [ОБ утверждении инструкции о порядке учета и диспансерного наблюдения за ВИЧ-инфицированными и больными СПИДом, содержащимся в следственных изоляторах и учреждениях исполнения наказаний Министерства внутренних дел Республики Узбекистан], [hereinafter “Regulations on HIV-positive prisoners”].

1339 Ibid.

1340 “Regulations on HIV-positive prisoners”.
informs the prisoner or detainee of an opportunity to undergo HIV counselling and testing voluntarily. The national expert group has noted that the wording of the “Internal regulations of penal institutions”, which provides for “strict control over timely identification and treatment of people with HIV and AIDS at penal institutions”, may be misinterpreted as encouraging or authorizing involuntary testing so as to identify HIV-positive persons.  

Since January 2008, antiretroviral therapy to treat people with HIV has been introduced in the penal system of Uzbekistan. Prisoners with HIV are supposed to be provided with enhanced nutrition during treatment if indicated and, on the basis of medical certificate attesting to the need for enhanced nutrition, prisoners are also entitled to receive additional parcels from those outside prison.

**HIV prevention in prisons**

The national expert group has reported that a project of peer HIV education among prisoners is being implemented in Uzbekistan’s prisons: prisoners are selected to be trained in HIV prevention methods and they in turn train other prisoners. Uzbekistan’s penal system does not currently implement HIV prevention activities such as condom distribution or harm reduction programmes to address risks associated with drug use.

Departmental documents of the penitentiary system do not prohibit the distribution and possession of condoms in prisons, but as noted above, the Criminal Code prohibits homosexual relations. This may be one factor impeding the implementation of condom distribution programmes among prisoners, since use of condoms may reveal details of prisoners’ private sexual activity and expose them to criminal prosecution.

As of the end of 2008, the penal system in Uzbekistan did not have measures to ensure prisoners’ access to sterile syringes. Prison regulations prohibit prisoners from possessing sharp cutting or piercing items but prisoners are allowed to purchase and store disinfectants, including chloramine. Distribution of a disinfectant such as chloramine in the penal system is a useful intervention. However, as UN technical agencies have advised, it should not be considered an adequate alternative to ensuring access to sterile injection equipment. While laboratory studies have shown that bleach can eliminate HIV (but not hepatitis C virus), field studies have raised considerable doubt that this or other disinfectants can be effective in real-life conditions, since many people who inject drugs cannot or do not consistently practice proper methods for disinfecting syringes. The likelihood of effective decontamination is even lower among prisoners, since the circumstances of drug use in prison are even less conducive to careful, repeated cleansing of injection equipment: prisoners may not have the time to do so, given the risk of being caught using prohibited drugs, and may often be using makeshift equipment that is more difficult to decontaminate effectively using disinfectants. Consequently, UN technical agencies have characterized access to disinfectants only as a “sub-optimal” approach, and have concluded that access to sterile injection equipment is the most effective measure to prevent the transmission of HIV and other blood-borne diseases among those injecting drugs in prisons. To strengthen HIV prevention efforts in prisons, including among people who inject drugs, the national expert group has recommended allowing the possession of not only disinfectants, but also condoms and needles.

**Compulsory treatment of drug dependence in prisons**

Court-ordered compulsory treatment of prisoners with alcohol and drug dependence is carried out in specialized penal institutions with different types of security. As a general rule, persons subject to compulsory treatment for alcohol or drug dependence are detained separately from other prisoners. For this purpose people are housed in isolated living sections of specialised drug dependence treatment facilities. Treatment

---

1341 “Internal regulations of penal institutions”, para. 74: 360.
1342 Joint Resolution of the Ministry of Internal Affairs (No. 19) and of the Ministry of Health of the Republic of Uzbekistan (No. 16), “On approval of the Regulations for provision of antiretroviral therapy to the HIV-infected and people with AIDS detained at pre-trial centres and penal institutions of the Ministry of Internal Affairs of the Republic of Uzbekistan” (27 November 2007).
1343 Information provided by the national expert group.
1344 “Internal regulations of penal institutions”.
1345 World Health Organization, UNAIDS and UN Office on Drugs and Crime, Interventions to Address HIV in Prisons: Needle and Syringe Programmes and Decontamination Strategies, Evidence for Action Technical Papers (Geneva, 2007);
1346 "Internal regulations of penal institutions", para. 375 and 77; Criminal Code, Article 96.
is provided by a narcologist in two stages: inpatient (for up to 2 months) and outpatient (for up to 2 years). Detoxification and the alleviation of withdrawal symptoms (using tranquilizers, nootropics and vitamins) are the main types of treatment; treatment is supervised by narcologists and general practitioners.

Prisoners may be released from work duties for purposes of testing and treatment in inpatient facilities of a medical unit or hospital; this includes prisoners undergoing compulsory treatment for alcohol or drug dependence. After a prisoner has completed a full course of treatment, the administration of the penal institution submits a report to the court with a request cancelling the treatment order.

Accordig to prison regulations, rehabilitation prior to release from prison includes social rehabilitation in relation to drug use. Preparation of a prisoner for a release shall start not later than 3 months prior to release and includes activities aimed at helping arrange employment and housing outside of prison. A month before a prisoner is released the medical unit of the penal institution notifies the health authority responsible for the area in which the prisoner is registered as a resident, and provides a report on the results of the person’s compulsory drug dependence treatment. If drug dependence treatment is not completed by the time of the prisoner’s release, he or she is registered by territorial health authorities and compulsory treatment is continued in health facilities after release.

**Transfers, absences and compassionate release from prison**

Currently, the Penal Code discriminates against prisoners based on HIV status and drug dependence in several ways.

First, after serving a portion of a sentence, prisoners deemed to be of “good behaviour” may be eligible to transfer from a colony with a stricter security regime to other, less strict facilities. However, prisoners ordered to undergo compulsory treatment for drug dependence and prisoners with infectious diseases (including HIV) are not eligible for such a transfer. Second, in exceptional circumstances (e.g., death or illness of relatives) prisoners can be permitted a temporary absence from the institution, for up to 7 days (not counting travel time). However, people who are ordered to undergo compulsory drug dependence treatment, and prisoners with infectious diseases (including HIV), are not eligible for such a leave. Third, prisoners deemed to be of “good behaviour” may be permitted a temporary unescorted absence outside the penal institution, after serving not less that one-third or one-half of their term, depending on the circumstances. However, prisoners who are ordered to undergo compulsory treatment and prisoners with infectious diseases (including HIV) are not eligible for such a benefit. According to the national expert group, such discriminatory measures creates a disincentive for prisoners to seek voluntary HIV testing, given this additional negative consequence that follows if the prisoner tests positive.

If a prisoner is temporarily unable to work because of illness, he or she may be released from work and referred to treatment. In the case of a permanent or long-term disability that considerably limits capacity to work, a patient shall be given disability status, which legally entitles person to disability support, discounted medicine and other benefits.

Under the Criminal Code, a person who develops a serious illness that prevents him or her from serving out a custodial sentence shall be released. According to a joint order of the Ministries of Health and Internal Affairs, prisoners with certain specified diseases are eligible for release on a compassionate basis; prisoners with AIDS are included on this list.

---

1347 “Internal regulations of penal institutions”, para. 387. Currently, in one of the country’s regions, an NGO is implementing a pilot project aimed at social rehabilitation after release from prison, including narcotic drug use-related social rehabilitation.

1348 Ministry of Internal Affairs, Order “On approval of the Regulations for provision of health services to persons detained at penal institutions and pre-trial centres of the Ministry of Internal Affairs of the Republic of Uzbekistan”, para. 327 [hereinafter “Regulations on health services”].

1349 Penal Code, Article 113.

1350 Penal Code, Article 82.

1351 Ibid.

1352 Penal Code, Article 83.

1353 “Regulations on health services”, para. 443.

1354 Criminal Code, Article 75.

1355 Ministry of Internal Affairs and Ministry of Health, Joint Order “On nomination of prisoners for release due to illness” [О предоставлении осужденных на освобождение от наказание по болезни].
6. DISCRIMINATION AND RESTRICTION OF RIGHTS

Although Uzbekistan’s Constitution does not define the concept of “discrimination”, it does include a basic equality rights provision. The Criminal Code envisages criminal liability for violating the principle of equality. National legislation also has a number of provisions protecting against discrimination based on HIV status.

The Law “On protection of public health” contains special anti-discrimination provisions applicable in the context of health:

Citizens of the Republic of Uzbekistan shall have an inherent right to health care. The state guarantees its citizens health care irrespective of age, gender, race, ethnicity, language, attitude towards religion, social background, views, personal and social status. The state guarantees its citizens protection against discrimination, despite the presence of any disease. Persons violating these provisions shall bear responsibility as established by the law.

Discrimination based on HIV status
The Law “On HIV” contains provisions specifically prohibiting the following forms of discrimination against people living with HIV and AIDS:

- termination of labour contracts;
- refusal to hire, except for certain professions (not specified in this law, but listed in a separate Government resolution); and
- refusal to admit a person to educational institutions or to health care facilities.

In addition, the Law “On HIV” prohibits limiting other rights and legitimate interests of people living with HIV and AIDS based on their status, as well as restrictions on housing and other rights and legitimate interests of their families.

Notwithstanding these provisions in the law, military conscripts who are HIV-positive are deemed unfit solely on this basis and hence subject to dismissal. In addition, some agencies and organizations have introduced their own rules mandating HIV testing in certain employment contexts (e.g., police officers; employees of the National Security Service; physicians, surgeons and gynecologists, dentists; food industry workers, people cleaning medical and cosmetic equipment, manufacture of medicine, care for newborns, child care). However, such practices amount to unjustifiable invasions of privacy and unjustifiable discrimination; it is incorrect to equate HIV-positive status with inability to perform such duties. The Government of Uzbekistan should abolish and prohibit such policies, in line with the stated principles of non-discrimination in Uzbek law (noted above) and international standards.

Discrimination based on drug use or dependence
The review by the national expert group also identified discrimination against people who use drugs as an area of concern, given the objective of strengthening HIV prevention and care among this vulnerable population. The expert group’s analysis suggested that Uzbek legislation has provisions that need to be revised, primarily due to the fact that they might cause stigmatization of people who use drugs and people living with HIV/AIDS. Currently, Uzbek law does not contain any provisions protecting people who use or are dependent on drugs from discrimination. Yet, as in other countries in the region, in Uzbekistan such discrimination based on drug use exists. Examples include the following:

1356 Article 18 of the Constitution states that citizens of Uzbekistan have equal rights and freedoms, and are equal before the law, without distinction on the grounds of sex, race, ethnic origin, language, religion, birth, beliefs and personal or social position.
1357 Criminal Code, Article 141.
1358 Law “On protection of public health”, Article 13 [unofficial translation].
1359 Law “On HIV”, Article 10.
1360 Ibid.
1361 Information provided by the national expert group.
1362 International Guidelines on HIV/AIDS and Human Rights, 2006 Consolidated Version, para. 22(a), (d), (j).
- **Discrimination in education or employment**: As a rule, if a student or employee is suspected of being under the influence of drugs, he or she is suspended from study or work and referred for compulsory drug testing in narcological facility.\textsuperscript{1363} Being under the influence of drugs may be considered a breach of the employment contract or rules of the educational institution, leading to termination of employment or suspension. People who use drugs are also restricted from performing certain activities. There is a list of occupations prohibited for people with drug dependence: health care and pharmacy workers, pharmaceutical industry, veterinarians, jobs connected with manufacturing, storage and sale of food and water, jobs connected with water supply, hydro-electrical jobs and artificial water bodies.\textsuperscript{1364} Refusal to undergo drug testing is an administrative offence for drivers.\textsuperscript{1365}

- **Discrimination in family relations**: Persons who are registered as drug users or people with drug dependence cannot become adoptive parents.\textsuperscript{1366} In cases of concern about child abuse or neglect, people with drug dependence per se may suffice as a basis for depriving someone of his or her parental rights.\textsuperscript{1367}

According to principles well established in international human rights law, limitations or infringements on human rights may only be justified in accordance with clear standards.\textsuperscript{1368} One key principle is that of non-discrimination, including based on health status. Indeed, as noted above, Uzbekistan’s own Law “On protection of public health” (Article 13) declares that: “The state guarantees its citizens protection against discrimination no matter what diseases they may have.” This should include drug dependence. It will be the very rare case in which denying certain rights or benefits to entire classes of persons based on their health status (e.g., diagnosis of HIV infection or drug dependence) will be justifiable. Rather, discriminating in education or employment or denying parental rights should require case-by-case justifications, based on an assessment of individual circumstances, rather than based on inaccurate, generalized assumptions about a person’s capacity to study, work or be a suitable parent based on health status.

\textsuperscript{1363} For example, as noted above, a person may be subjected to compulsory drug testing by police if there are “sufficient reasons” to believe the person is drug dependent or intoxicated or has used drugs without prescription: Law “On narcotic drugs and psychoactive substances”, Article 35.

\textsuperscript{1364} Ministry of Health, Ministry of Labour and Social Protection, and Trade Union Federation Council, Resolution “On establishing a list of professional activities restricted for people with drug dependence” [Об утверждении перечня видов профессиональной деятельности, на занятие которыми установлены ограничения для лиц, страдающих наркоманией], Resolution No. 8/46/14-10 (7 April 2003). Ministry of Health, Ministry of Internal Affairs and Ministry of Justice, Instruction “On the procedure of referring persons operating means of transportation for testing to determine use of alcoholic and other intoxicating substances and on testing” [Инструкция О порядке направления лиц, управляющих транспортными средствами на освидетельствование для установления факта употребления алкогольных или других одурманивающих веществ и проведения освидетельствования], No. 5/01-1/37/5/224 (18 April 1992).

\textsuperscript{1365} Administrative Code, Article 136.

\textsuperscript{1366} Family Code, Article 152.

\textsuperscript{1367} Family Code, Law No 607 (30 April 1998), Article 79.

7. RECOMMENDATIONS FOR LEGISLATIVE AND POLICY REFORM

After completing its review of legislation and practices in Uzbekistan, the national expert group has noted that the national legislation has many declarative provisions regarding HIV prevention and treatment which are not implemented in practice. In addition, the national expert group has emphasized that the national approach to high-risk groups such as people who use drugs and prisoners is still largely based on enforcement of criminal and administrative legal prohibitions, rather than healthcare interventions; this approach impedes HIV prevention and treatment among such groups.

The national expert group has also concluded that current provisions of the Law “On HIV” are inadequate to protect the rights and legal interests of people living with HIV and in some instances contributes to HIV-related stigma; in addition, it does not include some provisions that are needed or advisable to support effective HIV prevention and treatment measures, particularly among some vulnerable populations. Particular areas of concern include such things as ensuring proper counselling and confidentiality protections accompanying HIV testing, unjustifiable procedures of mandatory testing, and discriminatory treatment of non-citizens who are HIV-positive. These recommended amendments to the Law “On HIV” from the national expert group are reflected in a number of the recommendations below.

The recommendations presented here are aimed at addressing issues identified by the national expert group of Uzbekistan and by the project’s technical advisors. Suggested language of legislative amendments is shown in shaded boxes.1369

Administrative and criminal law issues

Recommendation 1: Remove penalties on possession of small quantities of drugs without intention to sell

As noted above, under the Administrative Code (Article 56), possession of drugs without an intention to sell is an administrative offence, punishable by a fine, in the case of “small” (небольшие) quantities (e.g., less than 0.01g in the case of cocaine). In the case of heroin, there are no “small” quantities according to current Uzbek law: even 0.001-0.005g of heroin is considered to be “exceeding small” (превышаю небольшие) quantities, which leads to criminal liability. In this regard, Uzbek law is one of the most punitive in the region. It imposes very harsh penalties for possession of miniscule amounts of drugs, even where there is no intent to sell. Given the nature of drug dependence as a chronic, relapsing condition, criminalizing repeated possession of small and minor quantities of a prohibited drug, even without intention to sell, criminalizes people with drug dependence. The Government of Uzbekistan should consider entirely removing criminal penalties for possession of “small” (небольшие) and “exceeding small” (превышаю небольшие) quantities where there is no intention to sell.1370 This could be achieved by enacting a provision such as the following in the Criminal Code (and in the Administrative Code as well, should the decision be made to remove administrative penalties as well for possession of such quantities without intention to sell):1371

Decriminalization [or depenalization] of possession without intention to sell

Notwithstanding anything in the Criminal Code of the Republic of Uzbekistan [and/or the Code of the Republic of Uzbekistan on Administrative Liability], the use and possession of a controlled substance in a small (небольшие) or exceeding small (превышаю небольшие) quantity with no intention to sell does not attract a criminal penalty [nor does it attract an administrative penalty].

1369 In many instances, the wording of proposed legislative amendments is adapted from model provisions in Legislating for Health and Human Rights: Model Law on Drug Use and HIV/AIDS (Toronto: Canadian HIV/AIDS Legal Network, 2006), online in both English (www.aidslaw.ca/modellaw) and Russian (www.aidslaw.ca/modellaw-ru). This publication, consisting of a series of 8 modules on different issues, was used as a key reference by UNODC, national expert groups and the project’s technical advisors during the review and assessment of national legislation in the countries participating in the project. Where relevant, citations below are to specific modules of that resource; the accompanying text and commentary to be found in those modules may be useful to legislators and policy-makers in implementing these recommendations.


Recommendation 2: Revise current amounts of narcotic drugs in order to depenalize possession of limited quantities with no intention of sale

As noted above, Uzbekistan’s definition of what constitutes “small” [небольшие] or “exceeding small” [превышающие небольшие] quantities of some narcotic drugs and psychotropic substances is particularly draconian, with the effect of criminalizing and administratively penalizing people who possess even quite limited quantities of drugs because of their drug dependence. Recommendation 1 above is aimed at removing criminal and administrative liability for possession of “small” and “exceeding” small quantities of drugs without an intention to sell. However, simply amending the law to state this is insufficient if the actual quantities defined as “small” and “exceeding small” remain very restrictive. Therefore, in conjunction with Recommendation 1, the Government of Uzbekistan should also review the current definitions with a view to liberalizing them and avoiding this unnecessarily strict, and counterproductive, penalization of people with drug dependence. Specifically, it should revise Article 274 of the Criminal Code and Article 190 of the Administrative Code (and the corresponding schedules) to redefine the “small” [небольшие] and “exceeding small” [превышающие небольшие] amounts of narcotic drugs and psychotropic substances, so that drug-dependent persons could possess quantities for personal use without fear of criminal or administrative prosecution, in order to preclude the unproductive conflict of the law enforcement with people who use drugs.

Recommendation 3: In qualifying an offence related to drugs, take into account pure amount of narcotic drug (without fillers)

Current drug Schedules in Uzbekistan define quantities of drugs “irrespective of (any) fillers”. According to the information presented by the expert group, in practice, this means that law enforcement expertise counts the entire amount of the mixture. Taking into account that the amount of the drug influences liability and often administrative or criminal charges, it is recommended to delete the words “irrespective of (any) fillers” from the Schedules. Defining various quantity ranges of different drugs, the law should make clear that this is a reference to a quantity of the pure drug itself, not the quantity that includes other fillers or additives that may be mixed with it.

Recommendation 4: Remove intoxication as aggravating factor for criminal liability

According to the Criminal Code (Article 56), being intoxicated by drugs or alcohol while committing a crime is an aggravating circumstance. However, whether or not a person is intoxicated does not affect the gravity of the harm of his or her crime, so it should not be considered as making the crime more serious. Rather, such a provision effectively discriminates against people accused of crimes based on their health status (i.e., dependence of drugs or alcohol), imposing harsher penalties for a given crime on people with this health condition. Article 56 should be repealed.

Recommendation 5: Create a clear legislative framework for harm reduction measures, including needle and syringe programmes

With the objective of supporting effective HIV prevention among injection drug users (including those in penal institutions), and protecting the public health more generally, the national expert group has recommended creating a clear legislative framework for harm reduction measures, including needle and syringe programmes (and including the disposal of used syringes). Wording of legislative provisions such as the following could be introduced to the existing Law “On HIV” or other suitable legislation:1372

---

ferrals to substance abuse treatment services. It includes needle exchange programmes, needle distribution programmes and other forms of sterile syringe distribution.

2. Staff of the sterile syringe programme may provide a range of material and services, including the following:
   a) sterile syringes and other related material for safer injection drug use, including sterile water ampoules, swabs, filters, safe acid preparations, spoons and bowls and other appropriate materials;
   b) material to enable safer smoking and inhalation of drugs, such as pipes, stems, metal screens, alcohol wipes and lip balm;
   c) condoms and other safer sex materials, such as water-based lubricants and dental dams, as well as information about reducing the risks of HIV and other sexually transmitted infections; and
   d) first aid in emergency situations.

3. Staff of sterile syringe programmes may provide information including, but not limited to, the following:
   a) drug dependence treatment services and other health services;
   b) means of protection against transmissible diseases, including blood-borne diseases such as HIV;
   c) the risks associated with the use of controlled substances;
   d) harm reduction information specific to the drug being used, including safe injecting and inhalation practices;
   e) legal aid services;
   f) employment and vocational training services and centres; and
   g) available support services for people with drug dependence and their families.

4. The state shall ensure access to sterile syringes for people who require them. Where sterile syringes are not otherwise available and there is demand, the state shall establish a sterile syringe programme out of public funds. The state may distribute sterile syringes through public health facilities or provide funding to community organizations to operate sterile syringe programmes.

Recommendation 6: Preclude criminal or administrative liability for harm reduction programmes

The harm reduction and outreach activities of non-governmental organizations targeting people who use drugs, such as programmes providing sterile syringes or other equipment to reduce harms associated with drug use (including HIV transmission), should be clearly exempt from possible liability. In particular, they should be exempt from liability under Article 274 (“involvement in drug use”) of the Criminal Code for their harm reduction activities, including distribution of injection equipment. Similarly, they should be exempt from liability under Article 56 of the Administrative Code for “possession” of residual quantities of drugs in used injection or other equipment or Article 276 of the Criminal Code (possession without intention to sell). Similarly, Article 36 of the Law “On narcotic drugs and psychotropic substances” (which prohibits “propaganda” of drug use) should also include a provision exempting harm reduction programmes from liability.

Specific legislative provisions such as the following could achieve this objective of protecting harm reduction programmes and their staff and volunteers from legal liability:1373

Exemption from criminal liability for sterile syringe and other harm reduction programmes

Nothing in the Criminal Code, the Administrative Code or other law prevents the supply of sterile syringes and other related material, or the giving of advice, information or instruction on the safe use of syringes and other related material, by staff of a sterile syringe programme or other programme aimed at reducing harms associated with the use of prohibited narcotics or psychotropic substances.

substances. For greater clarity, any prohibition in the Criminal Code or other law on “involvement in drug use” does not apply to providing equipment and information on drug use for the purpose of preventing the spread of HIV and other blood-borne infections or other injuries or harms that may be associated with drug use.

No penalty for possession of residual amounts of substances in drug use equipment

A person who is in possession of any residual amount of a prohibited narcotic or psychotropic substance that is contained in or on a syringe or other equipment used to ingest such a substance does not, by the mere fact of that possession, commit an offence under any law.

Recommendation 7: Eliminate or narrow the use of compulsory drug testing

Currently, Article 35 of the Law “On narcotic drugs and psychotropic substances”, authorizes compulsory drug testing if there are “sufficient grounds to believe” [достаточные основания полагать] that a person (a) has consumed illegal drugs, (b) is under the influence of alcohol or narcotics, or (c) has used a narcotic or psychotropic substance without a prescription from a medical doctor. As outlined above, such broad provisions unjustifiably infringe numerous human rights. Among other things, compulsory drug testing violates privacy and security of the person, without justification in most circumstances, since merely showing past use of drugs does not prove there is a risk of harm to self or others, which should be the only basis for possibly justifying an intrusion by the state into such rights. To eliminate unjustifiably broad provisions for compulsory drug testing, Article 35 of the Law “On narcotic drugs and psychotropic substances” should be repealed.

Recommendation 8: Decriminalize homosexual relations

The International Guidelines on HIV/AIDS and Human Rights (Guideline 5) recommend repealing laws that criminalize consensual sexual relations between adults of the same sex, since such laws violate human rights to liberty, security of the person, privacy and non-discrimination. Criminalizing men who have sex with men also undermines effective HIV prevention among this vulnerable populations and access to health services. Therefore, it is recommended that the Government of Uzbekistan repeal Article 120 of the Criminal Code.

Recommendation 9: Eliminate HIV-specific criminal law

Article 113 of the Criminal Code, which specifically provides for punishment for transmission and exposure to “venereal infections” and “AIDS disease”, should be repealed. In the case of intentional transmission of venereal or HIV infection, this could be dealt with as infliction of bodily harm that is covered by Articles 104-111 of the Criminal Code.

Recommendation 10: Decriminalize sex workers

It is recommended to repeal Article 190 of the Administrative Code (sex work) and Article 131 of the Criminal Code (organising brothels). The International Guidelines on HIV/AIDS and Human Rights recommend that with regard to adult sex work that involves no victimization, criminal law should be reviewed with the aim of decriminalising and legally regulating occupational health and safety conditions to protect sex workers and their clients, including support for safe sex during sex work. The criminal prohibition on recruiting people for sexual or other exploitation (Article 135 of the Criminal Code) and other existing criminal law provisions to deal with assault and coercion are sufficient for addressing human trafficking and exploitation, human rights abuses which require attention.

1374 Cases where sex between men is non-consensual should be covered under Articles 118-119 of the Criminal Code the same way as other cases of sexual assault.

1375 International Guidelines on HIV/AIDS and Human Rights (Guideline 4, para. 21(c)).
Drug dependence treatment

Recommendation 11: Amend the law on drugs to add provisions on drug dependence treatment or adopt a new law on drug dependence treatment

The current Law “On narcotic drugs and psychotropic substances” has only three articles regulating provision of drug dependence treatment. The national expert group has noted that, in light of Uzbekistan’s growing public health problem of drug dependence, there is a need to strengthen the legislative framework supporting effective drug dependence treatment; it has recommended the adoption of a new law for this purpose. According to the report of the national expert group, the Ministry of Health has tabled a draft of such a new law. To strengthen HIV prevention and treatment efforts among the vulnerable population of people who use drugs, this new law should have at least the following features:

- The law should include provisions for substitution therapy and harm reduction programmes, including in prisons and other custodial settings. (For more on prisons, see Recommendation 26 below.)
- The law should include provisions protecting patients’ rights in the context of drug dependence treatment, including ensuring access to voluntary treatment. Furthermore, at most compulsory treatment should be limited to urgent cases only as specified by the law and with safeguards to protect against unjustifiable compulsion. (For more on this point, see Recommendation 11 below.)
- The law should have strong provisions addressing discrimination against people living with HIV and people who use drugs.
- The law should elaborate some outreach activities in detail to ensure clear legal support of such activities.

Sample legislative provisions on several of these points have been prepared and could be adapted to the Uzbek national context.1376

Recommendation 12: Limiting compulsory drug dependence treatment

It is recommended that the Law on compulsory treatment of people with alcoholism and drug dependence should be repealed so as to abolish the possibility of compulsory treatment of drug dependence being applied to any person. In addition, Article 44 (paragraph 4) of the Law “On narcotic drugs and psychotropic substances”, which mentions compulsory treatment, should be struck out. As noted above, involuntary medical interventions are, absent some very clear and strong justification, a violation of basic human rights recognized in international law. At most, compulsory treatment for persons who are confirmed to be drug dependent (and not simply casual drug users) can only be justified as a last resort, in exceptional circumstances.

It is further recommended that, if compulsory drug dependence treatment remains in place in Uzbek law as a feature of the criminal justice system, notwithstanding the above recommendations, the Criminal Code should be amended to allow such drug dependence treatment to be an alternative to conviction and imprisonment in at least some cases of drug offences, rather than an additional part of the sentence on top of penal sanctions. As described above, this would be in conformity with the international drug control treaties.

Recommendation 13: Reinstate opioid substitution treatment programmes

Opioid substitution treatment is one critically important component of drug dependence treatment, and recognized in international best practice as key to HIV prevention among people who inject drugs. Uzbekistan became one of the very few countries which abolished this efficient and scientifically proven intervention. The Government of Uzbekistan is recommended to reinstate OST and scale up programmes. Methods of drug dependence treatment need to be expanded and brought in line with international

standards and good practice. In order to strengthen the legal basis for programmes of opioid substitution therapy, the national expert group has recommended adding several articles on OST into the *Law on narcotic drugs and psychotropic substances*, and in a new law on drug dependence treatment (as noted in Recommendation 9 above). For effective implementation of OST programmes, it is recommended to add medications such as methadone and buprenorphine to the list of essential drugs, reflecting a classification already made by the WHO, and to move methadone onto the list of drugs whose distribution is allowed to a limited degree (which list already includes buprenorphine).

**Recommendation 14: Ensure patient confidentiality**

The national expert group has noted that medical facilities report information about persons who are registered to law enforcement agencies, including cases in which people seek overdose treatment, which is at odds with the principle of confidentiality. As the expert group has pointed out, routine disclosure of such personal information, including health information, to law enforcement bodies not only infringes human rights but also undermines patients’ trust in medical workers and creates a barrier to seeking medical services, including treatment for drug dependence. The Ministries of Health and Internal Affairs should amend their joint order to repeal the sections that allow or require this sharing of confidential health information with law enforcement, and should instead prohibit health agencies from sharing such information about persons who use drugs with law enforcement agencies. Specifically, the law should be amended so as to permit (but not require) health professionals of such narcological centres to breach patient confidentiality only in circumstances where health professionals believe, in good faith and on reasonable grounds, that doing so is necessary to prevent imminent, serious harm to a patient or to another person. Additionally, health professionals should be required to share confidential information with law enforcement bodies only following a court order. All other instances of sharing information should be prohibited.

In addition, the *Law “On narcotic drugs and psychotropic substances”* and any new law on drug dependence treatment should also be amended to include explicit provisions strengthening the confidentiality of health information of patients receiving narcological assistance. Provisions such as the following should be added to the legislation:

(1) The confidentiality of all health care information shall be respected. Records of the identity, diagnosis, prognosis or treatment of any patient which are created or obtained in the course of drug dependence treatment:
   a) are confidential;
   b) are not open to public inspection or disclosure;
   c) shall not be shared with other individuals or agencies without the consent of the person to whom the record relates; and
   d) shall not be discoverable or admissible during legal proceedings.

(2) No record referred to in Section (1) may be used to
   a) initiate or substantiate any criminal charges against a patient; or
   b) act as grounds for conducting any investigation of a patient.

(3) Programme staff cannot be compelled under any other law to provide evidence concerning the information that was entrusted to them or became known to them in this capacity.

(4) All use of personal information of patients and programme staff in research and evaluation shall be undertaken in conditions guaranteeing anonymity, and any such information shall also be governed by Section (2) of this article.

---

1377 For model provisions that could be usefully incorporated into law to support OST programs that reflect human rights principles, see *Legislating for Health and Human Rights: Model Law on Drug Use and HIV/AIDS*, Module 2: Treatment for drug dependence, pp. 25-33.

1378 This sharing of patient information is based on a joint order from the Ministries of Internal Affairs and Health: Joint Order “On Approving the Instruction for the Procedure of Organizing Prevention Activities of Internal Affairs and Health Care Agencies with Persons Abusing Alcoholic Drinks or Narcotic Substances and Referrals to Obligatory Treatment of People with Chronic Alcoholism and Drug Dependence” [Об утверждении инструкции о порядке организации профилактической работы органов внутренних дел и здравоохранения с лицами, злоупотребляющими спиртными напитками или наркотическими средствами, и направления на принудительное лечение больных хроническим алкоголизмом или наркоманией ], Order No. 326/599 (27 December 1994).

Recommendation 15: Review, reform and perhaps abolish drug user registration

According to the national expert group’s assessment of the available evidence, the current system of drug user registration in Uzbekistan does not work, promotes human rights violations and police corruption, and impedes people’s access to drug dependence treatment (thereby undermining HIV prevention efforts among people who use drugs). Therefore, the Government of Uzbekistan should assess the effectiveness, efficiency, and economic benefit of this measure, with a view to reforming the current system, and possibly even abolishing it.

In order to protect and respect human rights, and to remove a reason for people to avoid seeking treatment for drug dependence or help with problematic drug use, Uzbekistan should abolish a central registry of people who use drugs and are dependent on it, which registry is then used in ways that can infringe human rights. To this end, Article 46 of the Law “On narcotic drugs and psychotropic substances” should be amended to repeal the provision on registration of people who use drugs; the relevant regulations that implement such a registry should also be amended. (Obviously, centres providing drug dependence treatment need to maintain some individualized information about patients in order to deliver treatment properly, and can and should continue to do so, as health facilities do with other patients receiving other kinds of health services, with proper protections for the confidentiality of patients’ health information.)

Recommendation 16: Expand measures used to treat overdoses

In 2009, naloxone was included in the list of essential medicines in Uzbekistan. This is a welcome development, which complies with international health care recommendations. In addition, in order to prevent deaths and other serious harms from overdoses among opioid users, outreach workers (including those working for non-governmental organizations and including “peers” who are themselves persons who use or have previously used drugs), should be given the legal right to distribute and administer medications such as naloxone in cases of overdose. This could be done by introducing provisions such as the following into the Law “On narcotic drugs and psychotropic substances” and/or a new law on drug treatment:

Outreach to people who use drugs

(1) “Outreach work” means a community-oriented activity undertaken to contact and provide information and services to individuals or groups from particular populations at risk of blood-borne diseases, particularly those who are not effectively contacted or reached by existing information and services or through traditional health care channels.

(2) “Outreach workers” include paid social or public health workers or unpaid volunteers (including peers) of governmental or non-governmental facilities.

(3) Outreach workers may include people who currently use drugs, people who formerly used drugs or people who do not use drugs and are trusted by people who use drugs.

Administration of an opioid antagonist

(1) The Ministry of Health must make provision for the appropriate training of outreach workers in the administration of opioid antagonists.

(2) An outreach worker may administer an opioid antagonist to another person if:
   a) the worker believes, in good faith, that the other person is experiencing a drug overdose; and
   b) the worker acts with reasonable care in administering the drug to the other person.

(3) An outreach worker who administers an opioid antagonist to another person pursuant to Section (1) shall not be subject to civil liability or criminal prosecution as a result of the administration of the opioid antagonist.

---

Taking into account incident of drug use in prisons, in order to preclude overdose complications in prisons, it is recommended to allow peer educators among prisoners and prison staff to administer naloxone in case of overdose in penitentiary institutions, and train them to use this emergency response medication.

**HIV testing and treatment**

**Recommendation 17: Introduce HIV prevention for people who use drugs in the HIV law**

Given the significant role of injecting drug use in the HIV epidemic in Uzbekistan, it is important that the Law “On HIV” reflect and support measures to prevent HIV and other harms to which people who use drugs are vulnerable, in accordance with international standards and recognized good practice. To this end, the Law “On HIV” should be strengthened by legislatively mandating harm reduction measures for people who use drugs and prisoners. This should include directives specifically to government bodies and agencies that have particular responsibilities in this area, such as the Ministry of Health and Ministry of Justice, as well as clearly directing law enforcement bodies (e.g., National Information and Analytical Centre for Drug Control) to cooperate with other government bodies and with non-governmental organizations to ensure the effective delivery and operation of harm reduction services (e.g., sterile syringe programmes, OST).

**Recommendation 18: Remove stigmatizing and unwarranted classification of HIV as dangerous disease. Discuss abolition of the lists of “socially significant diseases” and “diseases that pose threat to others”.**

Currently, the Law “On HIV” (Article 2) classifies HIV infection as “socially significant” and as a “disease that poses threat to others”, which classifications underlies the practice of mandatory testing upon the order of the Ministry of Health. While HIV infection is a serious disease, it is not casually communicable; it can only be transmitted through certain known exposures to bodily fluids. However, this classification of HIV may reinforce inaccurate fears about the transmissibility of HIV and thereby encourage increased stigma and discrimination against people living with HIV or perceived to be HIV-positive. Such stigma creates a further disincentive for people to seek HIV testing and to disclose their HIV-positive status if diagnosed positive, which impedes efforts to prevent and treat HIV. Therefore, it is recommended that legislators discuss the possibility of abolishing these lists as inducing stigma.

**Recommendation 19: Ensure informed consent to HIV testing**

The national expert group has reported that welcome steps are being taken to ensure a clear legal requirement to ensure people give consent to HIV testing that meets the requirements of informed consent, and that testing be accompanied by pre- and post-test counselling. While the details could be set out in different instruments (e.g., a regulation or order from the Ministry of Health), it would also be advisable to include in the Law “On HIV” provisions along the lines of the following:

No test for HIV or other blood-borne infection shall be undertaken except with the informed voluntary consent of the person being tested, which informed consent should be clearly documented in writing. All such testing must be accompanied by pre- and post-test counselling, in accordance with professional standards, as part of ensuring informed consent on the part of the person being tested.

**Recommendation 20: Improve blood safety and quality of HIV testing of blood donors**

The national expert group has recommended reviewing legal and regulatory acts to ensure the safety of donated blood and its components, and to introduce requirements for pre-test and post-test counselling of blood donors and the confidentiality of test results, in conformity with international standards.
Recommendation 21: Abolish or narrow mandatory HIV testing

Contrary to human rights principles and international guidelines, current Uzbek law authorizes mandatory or compulsory testing of numerous groups or in specific situations. The national expert group and/or the project’s technical advisors recommend a number of amendments in this area:

- Mandatory HIV testing for military recruits or personnel, or as a condition of admission or continued enrolment in academic institutions for military professions, is unjustifiable, and should be abolished, in accordance with international standards.\(^{1381}\)

- Similarly, the Government should repeal the provisions mandating premarital testing for HIV, STIs, drug and alcohol dependence or psychological disorders.\(^{1382}\)

- The Government should abolish the requirement that foreigners must prove HIV-negative status to obtain a visa to enter Uzbekistan (Article 12 of the Law “On HIV”); such a provision is a discriminatory and unjustified infringement on the right to free movement based on health status. The national expert group has also recommended that the provisions on deporting foreigners who test HIV-positive (Article 6 of the Law “On HIV”) be amended — specifically, by adding the limit that: “Foreign nationals and other non-citizens who are HIV-positive may be deported from Uzbekistan only in those cases when it is proved that they have infected other persons.” Even better would be to simply delete Article 6 altogether, and not single out HIV for this specific, discriminatory treatment. Instead, general provisions in Uzbek law about when non-citizens may be deported for criminal activity should be applied where justified in a given case.

- Regulations compelling HIV testing of people who are identified as sexual contacts of persons living with HIV should be repealed.\(^{1383}\) Such forced HIV testing, based merely on being identified as a past sexual contact, is an unjustifiable violation of bodily integrity, liberty and privacy.

- Compulsory HIV testing upon police request should be abolished.\(^{1384}\) This, too, is an unjustifiable violation of bodily integrity, liberty and privacy.

Recommendation 22: Repeal administrative liability for avoiding testing and treatment

The Administrative Code (Articles 57 and 58) make it an administrative offence for a person to avoid testing and treatment for HIV or STIs if there is “sufficient information” \(достаточные данные\) to believe he or she is infected; they also make it an offence for a person to refuse to disclose the source of his or her infection with HIV or another STI. These provisions are overly broad, essentially imposing compulsory testing and treatment, upon pain of penalty, even when there is no imminent risk of harm to others and even when a person is fully competent to make his or her own decisions about whether to seek testing or treatment. The infringement on personal privacy, bodily integrity and potentially liberty (if a penalty were imposed) is disproportionate and not shown to be necessary. Intervening to compel testing or treatment may only be potentially justifiable in exceptional circumstances when an independent authority, based on appropriate and adequate evidence, determines that intervention is necessary to prevent a significant, imminent risk of harm to other identifiable person or persons, or in cases where the person himself or herself is not competent to make an informed decision about whether or not to seek testing or treatment. Even where intervention to impose testing or treatment may possibly be justified, the objective should be to protect the individual or others from harm, not to impose penalties. These provisions should be repealed; other measures in law to authorize coercive intervention in exceptional circumstances, with appropriate safeguards, are a preferable approach.

Recommendation 23: Strengthen patient rights

While the Law “On protection of public health” currently recognizes some important rights of patients, it

\(^{1381}\) International Guidelines on HIV/AIDS and Human Rights, 2006 Consolidated Version, para. 22(a), (d), (j).


\(^{1383}\) Sanitary Rules.

\(^{1384}\) Ibid, para. 13.
should be strengthened — to the benefit of all patients, and not just those with HIV, STIs or drug dependence — by explicitly adding provisions such as the following to Article 31:

Every patient has the right:

a) to treatment and provided in accordance with good clinical practice;

b) to treatment without discrimination;

c) to meaningful participation in determining his or her own treatment goals;

d) to meaningful participation in all treatment decisions, including when and how treatment is initiated and withdrawal from treatment;

   aa) to exercise his or her rights as a patient;
   ab) to confidentiality of medical records and clinical test results; and
   ac) to be fully informed, including but not limited to the right to receive information about:
      i) his or her state of health;
      ii) his or her rights and obligations as a patient, as specified in any applicable law;
      iii) the procedure for making a complaint about health services received; and
      iv) cost and payment conditions and the availability of medical insurance and other possible subsidies.

ad) to decline treatment and testing

Furthermore, The expert group from Uzbekistan recommends, in order to enhance guarantees of protection of patient’s rights, to draft and adopt a Law “On health care and patients’ rights”, which would include fundamental international standards of patients’ rights, including confidentiality and privacy.

**Prisons**

**Recommendation 24: Ensure access to voluntary drug dependence treatment, including OST in prisons**

Given the high prevalence of drug dependence among those imprisoned, the significance of risky drug use practices in contributing to the HIV epidemic, and the importance of providing access to health services that respect human rights and help promote the highest attainable standard of health for all persons, it is recommended that Uzbekistan implement voluntary drug dependence treatment programmes in prisons. As OST is made available outside prisons, it should similarly be made available inside prisons as one important element of programmes for addressing drug dependence. To this end, if amendments are introduced to the Law “On narcotic drugs and psychotropic substances” and/or a new law on drug dependence treatment is adopted, so as to create a clear legal framework for substitution therapy that protects and promotes the human rights of patients receiving OST (as suggested above in Recommendations 10 and 12), those amendments should include explicit reference to providing access to OST to drug-dependent persons in prisons. Such a provision could be worded as follows (and could also be inserted into legislation such as the Penal Code):

**Opioid substitution treatment programmes in prison**

(1) The Ministry of Health, with the support and cooperation of the Ministry of Justice, shall establish opioid substitution treatment programmes in all prisons.

(2) Prisoners with opioid dependence shall be eligible for opioid substitution treatment in accordance with opioid substitution treatment guidelines applicable in the community.

(3) Opioid substitution treatment shall be available for free on imprisonment and throughout the duration of imprisonment.

---


(4) Opioid substitution treatment shall not be restricted to those on a course of opioid substitution treatment prior to imprisonment; all prisoners shall be entitled, if eligible, to being on opioid substitution treatment while incarcerated.

(5) Participation in the opioid substitution treatment programmes shall be offered on a voluntary basis to all prisoners with opioid dependence.

(6) Opioid substitution treatment programmes may include a variety of approaches, including maintenance treatment.

(7) The programme shall ensure that staff members, prison officers, policy makers and prisoners have factual information regarding opioid substitution treatment.

(8) The programme shall develop a comprehensive discharge planning system for prisoners nearing release, including a system for referral to opioid substitution treatment programmes in the general community.

**Recommendation 25: Strengthen HIV prevention in prisons and detention facilities**

In order to strengthen HIV prevention efforts in prisons and pre-trial detention facilities, in addition to making OST available to opioid-dependent prisoners, legislative amendments could mandate the introduction of harm reduction programmes in prisons. The Internal Regulations of penitentiary institutions should be revised to strengthen HIV prevention among prisoners. This would include removing the Internal Regulations’ provisions prohibiting prisoners from possessing needles and syringes, and inserting provisions that mandate access to bleach and sterile syringes, as well as ensuring access to condoms, and information related to risks of HIV transmission through unsafe sex or drug use. Provisions such as the following could be inserted into the Internal Regulations, the Law “On HIV” and/or the Penal Code, as deemed appropriate:


**Distribution and possession of condoms and other safer sex materials in prisons**

(1) The Ministry of Health and the Ministry of Internal Affairs shall ensure that condoms and other safer sex materials, along with appropriate information on their proper use and on their importance in preventing the spread of HIV infection and other sexually transmitted infections, are made available and easily accessible to prisoners in a manner that protects their anonymity.

(2) The Ministry of Health shall develop a plan for the disposal of used condoms that protects the anonymity of prisoners and the health of prison officers.

(3) The distribution and possession of condoms and other safer sex materials in prisons in accordance with this law shall not constitute a criminal nor administrative offence, nor are condoms and other safer sex materials admissible as evidence of sexual relations for the purposes of determining any criminal or administrative offence.

**Authorization of harm reduction programmes**

(1) Harm reduction programmes shall be implemented in all prisons according to the provisions set out herein, with the objective of reducing harms associated with unsafe use of drugs, including the risk of transmission of HIV or other blood-borne diseases.

(2) In order to prevent the spread of blood-borne diseases and minimize the health risks associated with drug use by prisoners, either the Ministry of Health or a local prison authority may authorize a specified person or organization (including non-governmental organisations) to deliver harm reduction programmes, including measures to supply sterile syringes and other related material to prisoners, as well as condoms and other materials to reduce the risks of HIV and other sexually transmitted infections.
Information
Staff of harm reduction programmes may also provide information including, but not limited to, the following:

(a) drug dependence treatment services and other health services;
(b) means of protection against transmissible diseases, including blood-borne diseases such as HIV;
(c) the risks associated with the use of controlled substances;
(d) harm reduction information specific to the drug being used, including safe injecting and inhal- ing practices;
(e) legal aid services;
(f) employment and vocational training services and centres; and
(g) available support services for people with drug dependence and their families.

Distribution and possession of sterile syringes and related material

(1) An authorized person or organization may distribute sterile syringes and related material via one or more of the following means:

(a) prison nurses or physicians based in a medical unit or other area(s) of the prison;
(b) prisoners trained as peer outreach workers;
(c) non-governmental organizations or health professionals who enter the prison for this purpose;
(d) one-for-one automated sterile syringe-dispensing machines.

(2) Wherever possible, sterile syringes and related material shall be made available to prisoners without the necessity of the prisoner identifying himself or herself to prison authorities.

(3) The Ministry of Internal Affairs, in consultation with the Ministry of Health shall establish rules for the safe storage of syringes possessed by prisoners in accordance with this law.

(4) The sterile syringe programme shall include measures to encourage safe disposal of syringes and monitor the number of syringes distributed and the number in storage.

(5) Sterile syringes and related material distributed by harm reduction programmes shall be used only in accordance with this law and any other applicable Regulations or institutional policies established by the relevant authority.

(6) The distribution and possession of syringes and related material in prison in accordance with this law shall not constitute a criminal nor administrative offence, nor shall such items be admissible as evidence of illegal drug use for the purposes of determining any criminal or administrative offence.

Availability of bleach as a disinfectant

(1) Bleach and instructions on using bleach as a disinfectant shall be made available in accordance with this law and any other applicable Regulations or institutional policies established pursuant to this law.

(2) Any such Regulations or policies established pursuant to Section (1) will:

(a) encourage participation of prisoners and their assistance in bleach distribution;
(b) ensure that bleach is available to prisoners in ways that preserve prisoners' anonymity; and
(c) ensure that in no instance shall a prisoner be required to approach a staff member in order to obtain bleach.
(3) Bleach distributed pursuant to this law shall be used only in accordance with this law and any other applicable Regulations or institutional policies established pursuant to this law.

(4) The distribution and possession of bleach in prison in accordance with this law shall not constitute a criminal nor administrative offence, nor shall such items be admissible as evidence of illegal drug use for the purposes of determining any criminal or administrative offence.

**Information and education programmes regarding HIV/AIDS, other blood-borne diseases and drug dependence treatment in prisons**

(1) The Ministry of Health shall develop and implement information and education programmes in every prison to help prevent the spread of HIV, other blood-borne diseases, and to address drug dependence among prisoners.

(2) In developing such programmes, the Ministry of Health shall use materials that are likely to be effective in reducing transmission of blood-borne diseases within prisons and outside prison following the release of prisoners, as well as providing information on treatment, care and support.

(3) Such programmes required by Section (1) may include peer education and use of non-Ministry of Internal Affairs personnel, including delivery of these programmes by community-based organizations.

(4) Materials shall, as much as possible, be available in the languages of the relevant populations, shall take into account the literacy level of the relevant populations, and shall be sensitive to the social and cultural needs of the relevant populations.

**Responsibility of the Ministry of Health for providing training and education**

The Ministry of Health is responsible for ensuring:

(a) that training and education are provided to staff and prisoners on a regular basis, and that such training and education include the principles of standard precautions to prevent and control blood borne diseases; the personal responsibility of staff and prisoners to protect themselves and others at all times; and information on post-exposure prophylaxis, if available;

(b) that training and education provided to prisoners also include information about available services and treatments; and peer education and counselling programmes that include the meaningful participation of prisoners as counsellors; and

(c) that prisoners and staff who may be exposed to blood and body fluids receive training in universal precautions.

**Recommendation 26: Ensure access to treatment for prisoners with HIV**

To ensure the right of access to equivalent health services, authorities responsible for correctional facilities need to implement universal access to antiretroviral therapy and other needed medications and treatment for HIV-positive prisoners. This obviously requires more than mere legislative amendments, but one important step would be to create a clear legal provision that recognizes prisoners’ rights in this area. To this end, a provision such as the following should be inserted into the Law “On HIV” and/or the Penal Code:

1388 Right to equal and adequate health care for prisoners

(1) HIV testing for prisoners is conducted only on a voluntary basis.

(2) A prisoner who has tested positive for infection with HIV is entitled to adequate health care, counselling and referrals to support services while in prison.

371

(3) Health practitioners shall provide prisoners with protection of their physical and mental health and treatment of disease of the same quality and standard as is afforded to those who are not imprisoned or detained.

While it is recommended that there be explicit reference to HIV, ideally, such an amendment would be worded more broadly to extend to needed health care services and medications beyond just HIV-specific care.

**Recommendation 27: Protect the confidentiality of prisoners’ health information**

The national expert group has recommended amendments to the *Penal Code*, including adding provisions regarding the obligation on prison system personnel to maintain the confidentiality of medical information of prisoners, including their HIV status. A provision such as the following should be inserted into the *Penal Code*:

**Confidentiality**

(1) All information on the health status and health care of a prisoner is confidential, and all health care procedures shall be designed so as to preserve the confidentiality of prisoners.

(2) Information referred to in Section (1) shall be recorded in files available only to health practitioners and not to non-health care prison staff. No mark, label, stamp or other visible sign shall be placed on prisoner’s files, cells or papers that could indicate his or her HIV status, other than necessary notations inside the medical file in accordance with standard professional practice for recording clinically relevant information about a patient.

(3) Information referred to in Section (1) may only be disclosed:
   - with the prisoner’s consent; or
   - where warranted to ensure the safety of other prisoners or staff;

with the same principles as generally applied in the community applying to the disclosure.

**Recommendation 28: Eliminate discrimination against prisoners with HIV or drug dependence**

To eliminate discrimination based on health status that is currently embedded in the law, the *Penal Code* should be amended in a number of ways, as follows:

- Repeal Article 113 of the *Penal Code*, which prohibits transferring prisoners who undergoing compulsory drug dependence treatment and prisoners with infectious diseases (including HIV) to lower-security institutions, which often provide better conditions.

- Repeal Articles 82 and 83 (and related provisions) of the *Penal Code*, which deny prisoners with an infectious disease (including HIV) and prisoners who have not completed drug dependence treatment the possibility of temporary absences from the penal institution (e.g., in the event of a family member’s death or illness; as a reward for ‘good behaviour’).

**Discrimination**

As noted above, current Uzbek law includes very important provisions prohibiting, in general terms, discrimination against people based on HIV-positive status. Yet at the same time, discrimination is a reality and Uzbek law itself contains discriminatory provisions in other areas. Legal protections against discrimination are important elements of successfully addressing the marginalization that contributes, in multiple ways, to people’s vulnerability to HIV and to experiencing even more severely the impact of HIV infection. Uzbek law can be strengthened in several ways in this regard in order to comply with human rights principles.
Recommendation 29: Eliminate HIV testing and other forms of discrimination against people living with HIV in employment or educational settings

The Law “On HIV” prohibits refusing to employ someone or dismissing someone from employment based on HIV status. However, despite this prohibition, current Uzbek law itself discriminates unjustifiably. As noted above (Recommendation 19), there is no justification for the current practice of mandatory HIV testing of military recruits or personnel and dismissal of those who test HIV-positive; this should be abolished.

Furthermore, it is not justifiable discrimination to maintain mandatory HIV testing of various other categories of employees (e.g., police officers; employees of the National Security Service and the Ministry of Defence; physicians, surgeons and gynecologists; food industry workers). Such testing is not necessary for HIV prevention purposes. Appropriate universal precautions can and should be taken by health care workers to protect both themselves and patients against the risk of transmission of various blood-borne diseases, and there is no risk posed by food industry workers who are HIV-positive. Nor is it correct or justifiable to assume that mere HIV-positive status means an employee is incapable of performing the essential duties of such jobs. The Government of Uzbekistan should ensure that amendments to the Law “On HIV” prohibit agencies and organizations from adopting such discriminatory policies and practices.

In addition, it would be useful to recognize explicitly that requiring HIV testing before or during employment or attendance at an educational institution amounts to unjustified discrimination based on health status. A legislative amendment to the Law “On HIV” should prohibit such practices. A provision could be worded as follows:

Discriminating against a person on the basis of his or her HIV infection or AIDS diagnosis is prohibited, including but not limited to such contexts as employment or education. It is unlawful discrimination to require that a person be tested for HIV as a condition of employment or enrolment in an educational institution, either before or during employment or enrolment.

Recommendation 30: Eliminate discrimination against drug-dependent persons in employment or educational settings

Requiring drug testing before employment or enrolment in an educational institution is also unjustified discrimination based on health status. Requiring testing for drug use during employment may only be potentially justifiable in quite limited circumstances, such as limiting testing to positions that are safety-sensitive and then only in cases where there are reasonable grounds to suspect impairment or possibly random drug testing of persons returning to work after receiving drug dependence treatment. There is a need to differentiate between people using drugs from time to time and those who are dependent on them.

The Law “On narcotic drugs and psychotropic substances” (or perhaps a new law on treatment of drug dependence, if adopted) should explicitly formalize the general rule that discrimination based on drug use is illegal (although there may be some circumstances in which differential treatment on this basis may be justifiable). The national expert group is of the view that such a provision in the law will help challenge stigma faced by people who use drugs. It is recommended that the law be amended to include a provision along the lines of the following:

Discrimination based on drug use

(1) Absent a reasonable justification given the circumstances of the case, it is prohibited to discriminate against a person, or a relative or associate of the person, on the ground that the person uses or has used drugs, or is perceived to use or have used drugs.
(2) It is unlawful discrimination to require that a person undergo drug testing as condition of enrolment in an educational institution, either before or during enrolment.

(3) It is unlawful discrimination to require that a person undergo drug testing as a pre-condition of employment. Making drug testing a condition of continued employment is permitted only in positions, as designated by [suitable government authority], where impairment while at work may pose a significant risk of harm to the individual employee or to others and where there are reasonable grounds to suspect that the individual employee may be impaired by drug use.

According to the national expert group, any limits on professional activities or occupations that people who use drugs may hold should be strictly rationalized and necessary. Such decisions should be made by a qualified committee, based on individual circumstances, and should be reviewed regularly (e.g., annually) to determine if they remain necessary.

**Recommendation 31: Respect and protect family relationships**

The Law “On protection of public health” (Article 13) states that citizens are protected against discrimination regardless of what disease they may have. Yet, as noted above, drug dependence can be a basis for denying someone’s application to adopt or deprivation of parental rights (custody of a child). This blanket discrimination simply on the basis of a health condition, without regard for individual circumstances and what is in “the best interests of the child”, is not justified. In light of this:

- Article 79 of the *Family Code* should be amended to repeal the explicit blanket provision on deprivation of parental rights if a person is drug-dependent.
- Article 152 of the *Family Code* should be amended to repeal the explicit blanket provision that prevents a person with drug dependence from adopting or receiving custody of a child.
## APPENDIX 1

Comparative tables of legal classification and threshold quantities of controlled psychoactive substances in project countries

### TABLE 1: Legal classification of selected controlled psychoactive substances

<table>
<thead>
<tr>
<th></th>
<th>Narcotic drugs and psychotropic substances, turnover of which is prohibited (including for medical purposes)</th>
<th>Narcotic drugs and psychotropic substances turnover of which is controlled (allowed for use for medical purposes, but strictly regulated)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Narcotic drugs</td>
<td>Psychotropic substances</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Narcotic drugs</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Psychotropic substances</td>
</tr>
<tr>
<td><strong>Azerbaijan</strong></td>
<td>Cannabis</td>
<td>Heroin Methadone</td>
</tr>
<tr>
<td></td>
<td>Cocaine</td>
<td>Khat Methadone</td>
</tr>
<tr>
<td></td>
<td>Hashish</td>
<td>Poppy seed Methadone</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Buprenorphine</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Themazipam</td>
</tr>
<tr>
<td><strong>Kazakhstan</strong></td>
<td>Hashish</td>
<td>Cocaine Codeine</td>
</tr>
<tr>
<td></td>
<td>Heroin</td>
<td>Poppy seed Morphine</td>
</tr>
<tr>
<td></td>
<td>Cannabis</td>
<td>Methadone</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Opium</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Thebaie</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Amphetamine Buprenorphine</td>
</tr>
<tr>
<td><strong>Kyrgyzstan</strong></td>
<td>Heroin</td>
<td>Cathinone</td>
</tr>
<tr>
<td></td>
<td>Desomorphine</td>
<td>Cocaine Methadone</td>
</tr>
<tr>
<td></td>
<td>Cannabis and cannabis resin</td>
<td>Morphine</td>
</tr>
<tr>
<td></td>
<td>Cannabis oil</td>
<td>Codeine</td>
</tr>
<tr>
<td></td>
<td>Poppy straw and poppy straw concentrate</td>
<td>Thebaie</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Opium</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Thebaie</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Amphetamine Metamphetatine Buprenorphine Cathine</td>
</tr>
<tr>
<td><strong>Tajikistan</strong></td>
<td>Cannabis</td>
<td>Cathinone</td>
</tr>
<tr>
<td></td>
<td>Hashish</td>
<td>Cocaine Codeine</td>
</tr>
<tr>
<td></td>
<td>Heroin</td>
<td>Methadone</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Morphine</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Thebaie</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Amphetamine Buprenorphine Cathine</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Themazipam</td>
</tr>
<tr>
<td><strong>Turkmenistan</strong></td>
<td>Amphetamine</td>
<td>Cathinone LSD</td>
</tr>
<tr>
<td></td>
<td>Cannabis</td>
<td>Thebaie LSD</td>
</tr>
<tr>
<td></td>
<td>Cocaine</td>
<td>Methadone</td>
</tr>
<tr>
<td></td>
<td>Heroin</td>
<td>Buprenorphine Trimeperidine Codeine</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Morphine Sombrevine</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Barbital Kethamine Temazipam</td>
</tr>
<tr>
<td><strong>Uzbekistan</strong></td>
<td>Cannabis</td>
<td>Khat Methadone</td>
</tr>
<tr>
<td></td>
<td>Cathine</td>
<td>Poppy (dried)</td>
</tr>
<tr>
<td></td>
<td>Heroin</td>
<td>Methadone</td>
</tr>
<tr>
<td></td>
<td>Cathinone</td>
<td>Buprenorphine</td>
</tr>
<tr>
<td></td>
<td>Hashish</td>
<td>Cocaine</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Codeine</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Morphine</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Thebaie</td>
</tr>
</tbody>
</table>
TABLE 2: Threshold amounts of selected controlled psychoactive substances triggering criminal or administrative liability
(Unless specified, amounts in grams)

<table>
<thead>
<tr>
<th>Substance</th>
<th>Azerbaijan</th>
<th>Tajikistan</th>
<th>Kazakhstan</th>
<th>Kyrgyzstan</th>
<th>Turkmenistan</th>
<th>Uzbekistan</th>
</tr>
</thead>
<tbody>
<tr>
<td>Heroin</td>
<td>Amount for personal use &lt;0,15</td>
<td>Small 0,5 - 10</td>
<td>Large 10 - 100</td>
<td>Extra large &gt;1000</td>
<td>Small 0,025 - 5,0</td>
<td>Large n/a</td>
</tr>
<tr>
<td></td>
<td>Large amount &lt;2</td>
<td>Large amount ≤1</td>
<td>Extra large ≥1,0</td>
<td>Large 5,0 - 200</td>
<td>Extra large &gt;250</td>
<td>Exceeding small 0,001 - 0,005</td>
</tr>
<tr>
<td>Hashish</td>
<td>Amount for personal use &lt;1</td>
<td>Small 0,5 - 5,0</td>
<td>Large 3 - 90</td>
<td>Extra large &gt;90</td>
<td>Small 1,0 - 25,0</td>
<td>Large 0,005</td>
</tr>
<tr>
<td></td>
<td>Large amount &lt;100</td>
<td>Large amount ≤500 - 5 kg</td>
<td>Extra large ≥200</td>
<td>Extra large &gt;250</td>
<td>Large 25,0 - 250,0</td>
<td>Exceeding small 0,1 - 1,0</td>
</tr>
<tr>
<td>Methadone</td>
<td>Amount for personal use &lt;0,02</td>
<td>Small 0,5 - 10</td>
<td>Large 0,01 - 1,0</td>
<td>Extra large ≥1</td>
<td>Small 0,02 - 1,5</td>
<td>Large 0,01 - 0,1</td>
</tr>
<tr>
<td></td>
<td>Large amount &lt;1,6</td>
<td>Large amount ≤100 - 1000</td>
<td>Extra large &gt;1</td>
<td>Extra large &gt;1,5</td>
<td>Large 0,02 - 1,0</td>
<td>Exceeding small 0,01 - 0,1</td>
</tr>
<tr>
<td>Cocaine</td>
<td>Amount for personal use &lt;0,02</td>
<td>Small 0,5 - 10</td>
<td>Large 0,01 - 1,0</td>
<td>Extra large ≥1</td>
<td>Small 0,02 - 1,0</td>
<td>Large 0,01 - 0,1</td>
</tr>
<tr>
<td></td>
<td>Large amount &lt;1</td>
<td>Large amount ≤100 - 1000</td>
<td>Extra large &gt;1</td>
<td>Extra large &gt;1,5</td>
<td>Large 0,02 - 1,0</td>
<td>Exceeding small 0,01 - 0,1</td>
</tr>
</tbody>
</table>

In Azerbaijan, possession of drugs for personal use leads to administrative liability; criminal liability starts for possession of drugs exceeding amounts for personal use; in Tajikistan, possession of drugs less than “small” amounts leads to administrative liability; in Kazakhstan, Kyrgyzstan, Turkmenistan and Uzbekistan possession of small amounts leads to administrative liability, possession of amounts exceeding small, leads to criminal liability.
<table>
<thead>
<tr>
<th>Substance</th>
<th>Amount for personal use</th>
<th>Large amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cannabis (Dried)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Amount for personal use</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Azerbaijan</td>
<td>5</td>
<td>500</td>
</tr>
<tr>
<td>Tajikistan</td>
<td>100 – 200</td>
<td>1000 – 1000</td>
</tr>
<tr>
<td>Kazakhstan</td>
<td>0.5 – 50</td>
<td>50 – 1000</td>
</tr>
<tr>
<td>Kyrgyzstan</td>
<td>≤20</td>
<td>≥500,0</td>
</tr>
<tr>
<td>Turkmenistan</td>
<td>5.0 – 50.0</td>
<td>50,0 – 1000</td>
</tr>
<tr>
<td>Uzbekistan</td>
<td>0.5</td>
<td>≥5.0</td>
</tr>
<tr>
<td>Cannabis (plant)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Amount for personal use</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Azerbaijan</td>
<td>n/a</td>
<td>n/a</td>
</tr>
<tr>
<td>Tajikistan</td>
<td>5 – 15 plants</td>
<td>≥15 plants</td>
</tr>
<tr>
<td>Kazakhstan</td>
<td>n/a</td>
<td>≥30 plants</td>
</tr>
<tr>
<td>Kyrgyzstan</td>
<td>≤15 plants</td>
<td>&gt;30 plants</td>
</tr>
<tr>
<td>Turkmenistan</td>
<td>5 – 10 plants</td>
<td>≥20 plants</td>
</tr>
<tr>
<td>Uzbekistan</td>
<td>n/a</td>
<td>≥10 plants</td>
</tr>
<tr>
<td>Poppy (dried)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Amount for personal use</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Azerbaijan</td>
<td>n/a</td>
<td>n/a</td>
</tr>
<tr>
<td>Tajikistan</td>
<td>5 – 10 plants</td>
<td>≥15 plants</td>
</tr>
<tr>
<td>Kazakhstan</td>
<td>n/a</td>
<td>≥30 plants</td>
</tr>
<tr>
<td>Kyrgyzstan</td>
<td>≤15 plants</td>
<td>&gt;30 plants</td>
</tr>
<tr>
<td>Turkmenistan</td>
<td>5 – 10 plants</td>
<td>≥20 plants</td>
</tr>
<tr>
<td>Uzbekistan</td>
<td>n/a</td>
<td>≥10 plants</td>
</tr>
<tr>
<td>Opium (raw)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Amount for personal use</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Azerbaijan</td>
<td>n/a</td>
<td>n/a</td>
</tr>
<tr>
<td>Tajikistan</td>
<td>5 – 10 plants</td>
<td>≥15 plants</td>
</tr>
<tr>
<td>Kazakhstan</td>
<td>n/a</td>
<td>≥30 plants</td>
</tr>
<tr>
<td>Kyrgyzstan</td>
<td>≤15 plants</td>
<td>&gt;30 plants</td>
</tr>
<tr>
<td>Turkmenistan</td>
<td>5 – 10 plants</td>
<td>≥20 plants</td>
</tr>
<tr>
<td>Uzbekistan</td>
<td>n/a</td>
<td>≥10 plants</td>
</tr>
</tbody>
</table>
The regulation of schedules/lists of narcotic drugs and psychotropic substances in the project countries varies.

In Azerbaijan, there are the three lists of narcotic drugs, psychotropic substances and precursors, the turnover of which is prohibited, limited or controlled: List I of substances turnover of which is prohibited entirely; List II of substances of which only limited turnover is permitted (i.e., substances may only be imported by state agencies); and List III of substances of which turnover of which is permitted and controlled by the state.\(^1\)

In Kazakhstan, there is a Schedule (Список) of narcotic drugs, psychotropic substances and precursors that are controlled.\(^2\) The Schedule consists of four Tables (Таблицы). Table I includes narcotic drugs and psychotropic substances the use of which for medical purposes is prohibited. Table II includes drugs and substances the use of which for medical purposes is strictly controlled. Table III contains drugs and substances that are used for medical purposes and are controlled by the state. Table IV contains precursors that are controlled in Kazakhstan.

The same approach as in Kazakhstan is taken in Uzbekistan\(^3\) and Turkmenistan.\(^4\)

In Kyrgyzstan,\(^5\) narcotic drugs are divided into four Schedules (списки). Schedule I lists narcotic drugs that are dangerous if misused but can be used for medical purposes. Schedule II lists less dangerous narcotic drugs that can be used for medical purposes. Schedule III lists some preparations of narcotic drugs that are exempt from some measures of control. Schedule IV lists narcotic drugs that are prohibited for use in Kyrgyzstan. Similar Schedules exist for psychotropic substances: Schedule I lists psychotropic substances prohibited within Kyrgyzstan. Schedule II lists psychotropic substances that are dangerous if misused but that can be used for medical purposes. Schedule III lists less dangerous psychotropic substances that can be used for medical purposes. Schedule IV lists less dangerous psychotropic substances which are prohibited for use. There are also separate lists of precursors and plants that contain narcotic substances prohibited for growing. The threshold amounts of morphine indicated in Table 1 are those for "other preparations of morphine"; the respective threshold amounts for "medicinal morphine" are as follows: 0.1, above 0.1 to 3.0, and above 3.0

In Tajikistan, there is a national list of narcotic drugs, psychotropic substances and precursors and their amounts that are prohibited for use.\(^6\)

---

\(^1\) Law of the Republic of Azerbaijan «On Lists of amounts of narcotic drugs, psychotropic substances and precursors, turnover of which is prohibited, limited or controlled in Azerbaijan, "Об утверждении списков наркотических средств, психотропных веществ и прекурсоров, оборот которых на территории Азербайджанской Республики запрещен, ограничен и контролируется"], 28 June 2005, № 961

\(^2\) The Schedule is adopted by the Law on narcotic drugs, psychotropic substances, precursors and (Закон Республики Казахстан от 10.07.1998 N 279-1 "О наркотических средствах, психотропных веществ, прекурсорах и мерах противодействия их незаконному обороту и злоупотреблению ими").

\(^3\) Law “On narcotic drugs and psychotropic substances” [О наркотических средствах и психотропных веществах], Law No. 813-1, (19 August 1999), Article 4; and State Commission of Uzbekistan on Drug Control, "List of narcotic drugs determining small, exceeding small and large quantities when detected in illegal possession or trafficking" (Перечень наркотических средств с отнесением их количества к небольшим, превышающим небольшие и крупным размерам при обнаружении в незаконном владении и обороте), Decision No. 3 (22 May 1998).

\(^4\) Law of Turkmenistan “On narcotics, psychotropic substances, precursors and measures to counter their illegal circulation” (О наркотических средствах, психотропных веществах, прекурсорах и мерах противодействия их незаконному обороту), 9 October 2004, Article 2.


APPENDIX 2

TOOL FOR THE ASSESSMENT OF NATIONAL LEGISLATION ON ACCESS TO HIV PREVENTION AND TREATMENT FOR PEOPLE WHO USE DRUGS AND PRISONERS

UNODC
CANADIAN HIV/AIDS LEGAL NETWORK
2010
1. DESCRIPTION

This Assessment Tool is designed for the purpose of analyzing national laws and their implementing instruments, and some elements of practice, so as to assess the availability and accessibility of HIV prevention and treatment for vulnerable groups of the population, namely, for people who use drugs and prisoners. Since the Assessment Tool focuses on assessing legislative guarantees of HIV prevention, treatment and care, the analysis made with its use may assist countries in reforming their legislation and policy to improve prevention and treatment of HIV-infection in general and especially these two groups of population. The Assessment Tool is based on international human rights standards, particularly the right to enjoy the highest attainable standard of health. This version of the Assessment Tool was prepared specifically for the region of Central Asia and Azerbaijan, the countries participating in this UNODC project, and was developed taking into account specific characteristics of political and legal systems in this region. The Assessment Tool can be adapted and used for assessments of the legislation and policy in other countries and regions.

The Assessment Tool was designed to help assess to what extent the national legislation guarantees respect for, and observance and protection, of human rights, including the availability of services to prevent and treat HIV to injection drug users and prisoners and protection against discrimination of these vulnerable populations. The Assessment Tool also includes such areas as adequate treatment of drug dependence and harm reduction services, as key elements of HIV prevention. The document contains questions and tables for assessing the extent to which national legislation corresponds to international legal standards and best practices in the field of HIV prevention and treatment. Completion of the Assessment Tool should help experts identify spheres where the national legislation and legal practice create barriers or lead to ineffective HIV prevention and treatment for vulnerable groups such as people who use drugs and prisoners, or can potentially violate human rights.

The Assessment Tool also includes guidelines to conduct an analysis for national experts. To assist national experts to use the Assessment Tool and carry out assessment of their national legislation, training modules were prepared on international human rights standards, the right to health, rationale for reforming laws and policies on drugs and prisons, and best international practices in the area of HIV prevention, treatment, and harm reduction services for people who use drugs and for prisoners.

Structure of the Assessment Tool

The Assessment Tool is divided into the following sections:

1. **International law**: international treaties applicable to the country.
2. **National legal system**: the basics of judicial and legal systems, legislative drafting and amendments.
3. **National programmes/plans/strategies on drugs and HIV**: the presence of provisions and activities aimed at treatment of drug dependence, and the prevention of HIV among people who use drugs and prisoners.
4. **Administrative and criminal law issues**: analysis of administrative and criminal law provisions related to drug use and possession of small amounts of narcotic drugs for personal use, referral for drug testing by law enforcement, the availability of diversion programmes for non-violent drug-related offences.
5. **Health care services**: availability and accessibility of public health services; drug dependence treatment; HIV testing and treatment; patients’ rights, including the confidentiality of health information; and the availability of harm reduction services.
6. **Prisons**: HIV prevention and treatment measures in the penitentiary system, including measures to address drug use in prisons (e.g., drug dependence treatment, needle and syringe programmes)
7. **Anti-discrimination provisions**: limitations of rights of people who use drugs and people living with HIV in national legislation; participation in decision-making.

2. METHODOLOGY

The Assessment Tool is based on international human rights standards and was developed taking into account international declarations and recommendations on drugs, prisons, HIV and AIDS by interna-

A key reference document used in developing the Assessment Tool is *Legislating for Health and Human Rights: Model Law on Drug Use and HIV/AIDS* (Toronto: Canadian HIV/AIDS Legal Network, 2006), online in both English ([www.aidslaw.ca/modellaw](http://www.aidslaw.ca/modellaw)) and Russian ([www.aidslaw.ca/modellaw-ru](http://www.aidslaw.ca/modellaw-ru)). The model law gives examples of best legislative practices of HIV prevention and treatment for people who use drugs and prisoners. The model law resource should be used by national experts as a basis for drawing up the recommendations on reforming the legislation. Also, the following legal documents were used in preparation of the Assessment Tool:

- *Universal Declaration of Human Rights* (1948);
- *International Covenant on Civil and Political Rights* (1966);
- *International Covenant on Economic, Social and Cultural Rights* (1966);
- UN Committee on Economic, Social and Cultural Rights, *General Comment No. 14: The Right to the Highest Attainable Standard of Health* (2000);
- WHO Guidelines on HIV infection and AIDS in Prisons (1993);
- UN General Assembly, *Basic Principles for the Treatment of Prisoners* (1990);
- UN General Assembly, *Standard Minimum Rules for the Treatment of Prisoners* (1955);
- UN General Assembly, *Declaration of Commitment on HIV/AIDS* (2001);
- UNDCP Legal Affairs Section, *Flexibility of treaty provisions as regards harm reduction approaches*, Decision 74/10 (2002);
- *Dublin Declaration on Partnership to fight HIV/AIDS in Europe and Central Asia* (2004); and many others.

3. **INSTRUCTIONS ON USING THE ASSESSMENT TOOL**

Within the scope of the present project, the national experts should:

- Inform themselves about international standards listed above and with the *Model Law on Drug use and HIV/AIDS*;
- Complete the Assessment Tool, answering all questions, using international, regional and bilateral treaties, national laws, implementing legislation, regulations and instructions;
- Conduct interviews with stakeholders, including NGO staff, people who use drugs, people living with HIV and current or former prisoners.
- Discuss outcomes of the legislative analysis with corresponding national government bodies, representatives of civil society, people living with HIV and people who use drugs and other stakeholders;
- Draft recommendations on how to improve national legislation governing response to HIV, and how to remove legislative barriers to effective HIV prevention and treatment for people who use drugs and prisoners in the country;
- Carry out meetings, roundtables, discussions and trainings for national decision-makers and stakeholders on international standards and proposed recommendations.

While completing the Assessment Tool, national experts will compare the existing national legislation to the international standards in the field of human rights and to the *Model Law on Drug use and HIV/AIDS* and develop recommendations on reforming the national legislation in the field of prevention of HIV among people who use drugs and prisoners. During the analysis of national legislation and regulations, experts should take into account: laws and implementing legislation that might directly or indirectly contribute to discrimination, stigmatization or limitation of the rights of people who use drugs, sex workers,
prisoners and other groups at risk of HIV; provisions or policies that increase vulnerability to HIV, including strict administrative and criminal legislation and policies in relation to people who use drugs.

Documents to include in the analysis
- National programmes/strategies on HIV, drug control and reform of the penitentiary system;
- Constitutions, codes and laws;
- Presidential decrees, ministerial and departmental resolutions and instructions;
- Guidelines on interpretation of the laws, published for the public by an establishment or enforcement authority;
- Court decisions;
- Other documents relevant to the subject.

It is important to gather and take into account all relevant documents. Provisions of the Constitution or criminal and administrative codes might be subject to broad interpretation by implementing acts such as instructions or government resolutions, which might unintentionally negatively affect people who use drugs and prisoners. When conducting an assessment it is necessary to identify such legal documents, although they can be difficult to find.

Some sections of the Assessment Tool ask experts to collect information about statistics, facts and practices. In some respects, conclusions of the assessment should be based not only on legal provisions, but also on the reality of how these provisions are (or are not) implemented. In cases where national experts have doubts about the enforceability and practical effects of the legislation, they should provide comments. For example, if harm reduction programmes are not explicitly prohibited by laws, but are not implemented effectively because outreach workers or people who use drugs are afraid of prosecution, this situation should be described in the report.

Members of the expert group might identify other pertinent areas. In this case, expert group members should include these areas in their analysis and explain their relevance. At the end of each section, there should be a summary of the collected information and key conclusions and recommendations. Exact citations of provisions of laws and regulations should be noted. If possible, a copy of the laws and regulations should be made and kept available for review.

Conducting interviews
To ensure comprehensive analysis, national experts are asked to conduct interviews with a suitable number of people who have experience in the area in question (service providers, people who use drugs and prisoners). This is required in order to have a clear picture about the situation in the country in a certain area; to identify situations in which laws are not observed or are interpreted broadly and thus hinder access to HIV prevention and treatment for people who use drugs and prisoners. During the interviews, national experts are requested to get a picture on the real availability of HIV prevention programmes and medical services to people who use drugs and prisoners. To this end, national experts should interview at least one representative from each of the following groups:

1) people who use drugs;
2) people living with HIV;
3) sex workers;
4) prisoners or former prisoners and organizations working in prisons;
5) harm reduction service providers, outreach workers;
6) prison staff;
7) health care personnel, drug dependence treatment specialists, AIDS centre staff;
8) law enforcement personnel;
9) judges, public prosecutors working with offences related to drugs.

Preparing the country report
National expert reviewers should include the following information in the country report:
- completed Assessment Tool, identifying gaps in legislation or its enforcement;
- priorities identified in reforming the legislation to improve HIV prevention and treatment for peo-
people who use drugs and prisoners;
- draft recommendations;
- if feasible, draft actual legislative amendments (which could be based on the *Model Law on Drug Use and HIV/AIDS*); and

a plan developed for introduction of the recommendations in the country.

Findings of the country report will be used for a comprehensive integrated report, summarizing conclusions and recommendations from all project countries, which will later be used to advocate proposed reforms.

**Self-assessment check-list**

National experts are also asked to fill in the self-assessment check-list, designed to assess the conformity of national legislation with the *Model Law on Drug use and HIV/AIDS* and international standards in the field of human rights and harm reduction. The check-list will be useful for monitoring the development and the review of the national legislation in the area of HIV prevention and treatment for people who use drugs and prisoners.

**Training for national experts on international standards of HIV prevention and treatment and the application of the Assessment Tool**

In the course of the training, detailed information on human rights-based approaches to HIV prevention and treatment, international human rights standards and especially the right to health are presented to national expert teams. Provisions of the *Model Law on Drug use and HIV/AIDS*, and UN recommendations on HIV, drug use and drug dependence treatment, and HIV prevention and treatment in prisons should be covered by trainers. Effective, evidence-based harm reduction interventions are also covered (e.g., needle and syringe programmes, opioid substitution therapy, voluntary treatment of drug dependence), as described in the Training Module (see Appendix 3).

It is expected that during the training, participants will:

- deepen their knowledge of international human rights standards in the area of HIV prevention and treatment for people who use drugs and prisoners;
- acquire knowledge on the *Model Law on Drug Use and HIV/AIDS* as a key reference for the future legislative reforms;
- acquire knowledge and skills on using the Assessment Tool for reviewing national legislation and collecting strategic documents relevant to the availability of HIV prevention and treatment services to people who use drugs and people in prison;
- draft a plan for reviewing and revising national legislation and preparing recommendations for amendments;
- agree on sharing the workload among the members of the working group, based on their respective areas of expertise, and identify priorities; and
- discuss possible difficulties in working with the legislation, the subsequent reforms of the legislation and legal practices, and ways to overcome them.
4. QUESTIONS FOR ASSESSMENT OF LEGISLATION

I. International Law

1. What international and regional conventions and treaties has the country ratified in the area of human rights?

Table 1. International and regional conventions and treaties related to human rights the country ratified

<table>
<thead>
<tr>
<th>International document</th>
<th>Date of ratification (or not ratified)</th>
<th>Reservations</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>International Covenant on Civil and Political Rights (1966)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Optional Protocol to the International Covenant on Civil and Political Rights (1966)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>International Covenant on Economic, Social and Cultural Rights (1966)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Convention Against Torture (1984)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other (please list)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

2. Which international and/or regional human rights organizations has the country joined?

3. What is the status of international treaties on human rights with respect to national laws? (Do the provisions of national law stipulate the supremacy of international law?)

4. What conventions or other documents related to controlling narcotics has the country ratified or endorsed?

Table 2. Conventions or other documents related to drug control ratified by the country?

<table>
<thead>
<tr>
<th>International document</th>
<th>Date of ratification (or not ratified)</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Single Convention on Narcotic Drugs 1961</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Protocol Amending the Single Convention on Narcotic Drugs, 1972</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Convention on Psychotropic Substances, 1971</td>
<td></td>
<td></td>
</tr>
<tr>
<td>United Nations Convention Against Illicit Traffic in Narcotic Drugs and Psychotropic Substances, 1988</td>
<td></td>
<td></td>
</tr>
<tr>
<td>UN General Assembly’s Declaration on the Guiding Principles of Drug Demand Reduction, 1998</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other (please list)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

5. What bilateral or regional agreements on drugs control has the government signed?

II. National legal system and relevant agencies for HIV and controlled drugs

6. Describe the hierarchy of national legislation (constitution, codes, laws, regulations).

7. Is there a Constitutional Court in the country? What persons and entities have right to bring a case before the Constitutional Court of the country?

8. What persons and associations possess the right of initiating a new legislation?

9. Are legislative acts and bylaws subject to publication in official media?

10. Describe the judicial system of the country. Which courts have jurisdiction over the cases involving
drugs? Are there specialized courts that deal with drug–related cases?

11. What impact (if any) do judicial precedents have on the development of legislation and legal practices?

12. What categories of people are eligible for free legal assistance (appointed lawyer)? Do people charged with drug-related crimes have access to free (and adequate) legal assistance? Is there any agency that provides free legal assistance to the population?

13. Describe the national system of human rights protection, including agencies and their powers.

14. Describe the jurisdiction and powers of law enforcement bodies related to prevention and investigation of drug-related crimes and offences.

15. Describe the system of drug control, its objectives and functions. What agency is responsible for the development and implementation of drug control legislation and policy?

16. Describe national HIV agencies, including 1) their functions and powers and; 2) the participation of people who use drugs and people with HIV in their activity.

III.A. National programmes, strategies and action plans on drugs

17. What national programmes, strategies or action plans on drugs exist in the country? Describe the main elements of the programme, including: (1) drug use prevention; (2) drug dependence treatment; (3) harm reduction services; (4) law enforcement measures;

18. Does the programme mention preventive measures (including harm reduction services) and drug-dependence treatment in penal institutions?

19. Does the programme have a prescribed budget? What are the sources of financing of the programme? What portion of the budget is spent on drug-dependence treatment and harm reduction services?

20. What bodies are responsible for development of the programme, its implementation and assessment of its effectiveness?

21. How does civil society participate in the process of development and implementation of the programme (e.g. organizations working in the field of harm reduction, people who use drugs)? Does the programme include any mechanisms for civil society control over implementation of the programme?

22. What could be done in order to increase the effectiveness of the programme? Interviews with representatives of civil society may be particularly useful in answering this question.

Describe the elements of the programme using the following table.

Table 3. Drug control programme

<table>
<thead>
<tr>
<th>Elements of the programme</th>
<th>Included / not included in the programme</th>
<th>Institution or governmental body responsible for implementation of the programme</th>
<th>Comments/brief description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Elements/sections of the programme (law enforcement measures, drug use prevention, drug-dependence treatment, harm reduction services)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Provisions related to interventions for drug use prevention</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Provisions related to treatment for drug dependence (including opioid substitution treatment)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Provisions related to harm reduction services (including sterile syringe programmes, pharmacy-based distribution of syringes, safe injection facilities, condom distribution programmes, outreach services)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Provisions related to involvement of people who use drugs in response to drugs</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Provisions related to addressing drug use in prisons (prevention of drug use, treatment for drug dependence, harm reduction services)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Provisions related to specific preventive measures aimed for other groups (sex workers, minors, women)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
IIIB. National programmes, strategies and action plans on HIV

23. What national programmes, strategies or action plans on HIV prevention exist in the country? Describe the main elements of the programme including groups of population to which the programme is directed.

24. What actions are directed to the prevention and treatment of HIV infection among specific groups? (Describe the action and the group to which it is directed)

25. Does the programme mention harm reduction services?

26. Is approval of the national drug control agency needed to expand preventive measures on HIV (e.g. for expanding of sterile syringe programmes or opioid substitution treatment)?

27. How is this programme financed? Is financing adequate? What percentage of the programme’s budget goes to HIV prevention?

28. What bodies are responsible for development of the programme, its implementation and assessment of its effectiveness?

29. How does civil society participate in the process of development and implementation of the programme (e.g., organizations working in the field of harm reduction, people who use drugs, people living with HIV)? Does the programme include any mechanisms for civil society control over implementation of the programme?

30. Does the programme contain any provisions on human rights of people living with HIV? Or does it contain any provisions for preventing discrimination of people with HIV and guarantee privacy of people living with HIV?

31. Does the programme contain provisions on HIV prevention and treatment in prisons?

32. What could be done to increase effectiveness of the programme? (Interviews with civil society representatives may be particularly useful in answering this question.)

33. Are there other national programmes, strategies or action plans addressing prevention of sexually transmitted infections (STIs), viral hepatitis or tuberculosis? Do they include provisions related to specific groups of people (e.g. people who inject drugs)? Do they include provisions on prevention and treatment of the above diseases in prisons?

Please describe the elements of the programme using the following table.

**Table 4. Programme on HIV prevention**

<table>
<thead>
<tr>
<th>Elements of the programme</th>
<th>Included / not included in the programme</th>
<th>Institution or governmental body responsible for implementation of the programme</th>
<th>Comments/ brief description</th>
</tr>
</thead>
<tbody>
<tr>
<td>The main elements/sections of the programme (prevention and treatment of HIV)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Provisions on harm reduction services</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Provisions related to actions on HIV prevention for general population</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Provisions related to actions on HIV prevention for injecting drug users (including sterile needle and syringe programmes, pharmacy-based distribution of syringes, safe injection facilities, condom distribution programmes, outreach services and opioid substitution treatment)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Provisions related to actions on HIV prevention in prisons (including educational activities, sterile needle and syringe programmes, condom distribution programmes, outreach services and opioid substitution treatment)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Provisions on specific actions aimed at other groups of population (pregnant women, sex workers, men who have sex with men)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Provisions on actions aimed at HIV treatment (including antiretroviral therapy, free medical service for people with HIV and etc.)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Provisions on reduction of stigma and discrimination</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
IV. Criminal and administrative law issues

Please indicate all legislative provisions, references and quotations from legislation; if possible, include excerpts.

34. Does drug use per se lead to criminal or administrative liability?
35. Does the legislation on drugs include a notion of “amount for personal use” or “average consumption dose”?
36. Does the Criminal Code make a distinction between drug possession for personal use and possession for sale?
37. How is drug possession with no intent of sale regulated in the country? If possible, please give details on different drug substances.
38. Please describe the national lists (schedules) of drug substances. Which governmental body or institution is responsible for developing and approving these lists?
39. What is the age of criminal and administrative responsibility for drug-related crime?
40. What drug-related offences lead to administrative liability?
41. Are there any provisions in national legislation stipulating alternatives to criminal liability for non-violent crimes involving drugs?
42. Does legislation provide for non-custodial sentences for offences involving drugs (e.g. conditional sentence, probation, public works)? Would the punishment change in the case of a repeat offence?
43. Does the Criminal Code consider being under the influence of drugs as an aggravating factor?
44. Can drug dependence treatment constitute an alternative to normal criminal sentencing?
45. Can compulsory treatment of drug dependence be used as an alternative to incarceration?
46. Are there provisions in the legislation that exempt the staff or volunteers of harm reduction programmes from possible criminal or administrative liability?
47. Can possession of a syringe or other related materials for drug use lead to liability under national legislation?
48. Can possession of drug-use materials and equipment be considered as facilitation (or incitement) of drug use? What legislation defines and regulates possession of these materials?
49. Can trace amounts of a drug in a syringe or on other related material for drug use be considered a legally sufficient reason for administrative/criminal liability?
50. Is there a prohibition on patrolling by police of the sites providing harm reduction programmes and pharmacies?
51. What are the legal grounds for police to refer a person for drug testing? (suspicion of drug use, suspicion of committing an offence)
52. Can confiscation of property be imposed in drug-related cases?
53. Is pre-trial detention usually imposed in drug-related offences?

Please create a table of liability for drug-related offences and indicate the maximum and the minimum penalties for these crimes. In cases where the penalty depends on the type of drug used, please indicate these drugs (e.g., heroin, cocaine and other commonly used drugs).

54. Does refusal to undertake drug/HIV/STI testing or HIV/drug dependence/STI treatment constitute a criminal or administrative offence?
55. Does sex work/prostitution constitute a criminal or administrative offence?
56. Does sexual intercourse between two consenting adults of the same sex constitute a criminal or administrative offence?
57. Does transmission of STI and HIV constitute a criminal or administrative offence?
58. Please describe other drug-related offences that might lead to administrative liability (e.g. appearance in public under drug intoxication, etc.)

V. Health care services for people who use drugs

Background information and statistics
Please indicate the number of registered drug users and people dependent on drugs in the country, and people receiving drug dependence treatment, including OST. Please indicate the number of people liv-
Drug testing
71. In which circumstances and what bodies can refer an individual to take a drug use test? What documents regulate such referrals?
72. In which circumstances can drug testing take place without the consent of the individual? What are the consequences of refusing to take a drug test?
73. Is there drug testing in schools, universities or other educational institutions? What are the consequences of refusal to undergo drug testing in educational institutions?
74. Is there drug testing in the workplace in the country? What are the consequences of refusal to undergo drug testing requested by employers?
75. Please describe, where applicable, whether or not people who use drugs are limited in the following rights: (a) to get a driving license; (b) to adopt children; (c) to be appointed to certain positions; (d) to vote; (e) to go to certain districts of the city; etc. Please make a list indicating duration of such limitation.

Drug dependence treatment
76. Has there been research conducted in the country on the effectiveness of existing drug dependence treatment methods?
77. How is “drug dependence” understood in the country according to national legislation (as a crime, as a disease, as a disability)?
78. Is there a unified regulatory act on drug dependence treatment? If not, which legislation or regulations have provisions on drug dependence treatment?
79. Are there national standards of drug dependence treatment? If yes, please describe these standards (whether or not they include opioid substitution therapy, post-treatment medical care, rehabilitation).
80. How is payment for drug dependence treatment regulated? For which services related to the drug dependence treatment are there extra charges (officially and in practice)?
81. Is there registration of drug users (and/or drug-dependent individuals) in the country? If yes, for what duration such registration is valid? What are the terms of de-registration? What limitations in rights can
such registration entail?
82. What body/institution maintains the registration database?
83. How is confidentiality of information held in such a registry protected? What bodies or officials have
access to registration database? Under what circumstances is the exchange of information between
health care institutions and the law enforcement permitted by law (if at all)?
84. Are medical workers responsible for reporting to law enforcement bodies cases of drug overdose and/
or cases of clients seeking treatment for drug dependence?
85. What organizations (public or private) are allowed to provide drug dependence treatment (including
OST)?
86. Is a license or other document needed in order to provide any of the following services: detoxification,
in-patient treatment, out-patient treatment, substitution therapy by buprenorphine, methadone or other
types of substitution therapy, psychological methods, 12-steps method, etc.?
87. Which elements of drug dependence treatment can be done by in-patient or out-patient drug de-
pendence clinics?
88. Are there provisions in national legislation providing compulsory drug testing while on drug depend-
ence treatment? Can testing positive for drug use lead to exclusion from drug dependence treatment
programmes?
89. Is long-term opioid substitution therapy (i.e., maintenance treatment) available in the country? If yes,
please describe eligibility for the programme, duration of the treatment, bodies or institutions running
the programme, terms of exclusion from the programme, and completion of the programme.
90. If there is no OST, please assess a possibility of introduction of OST in the country.
91. Do persons following OST programmes have the right to be part of the determination of the dose they
receive? Does the prescribing physician have discretion to initiate take-away doses to patients?

Compulsory drug dependence treatment
92. Does compulsory drug dependence treatment exist outside of prisons/ in prisons? What are the legal
grounds for imposing compulsory treatment and which body has an authority to impose it?
93. What are the legal consequences for failure to comply with the rules of treatment or refusing the
treatment?
94. Please indicate duration and terms of termination of compulsory treatment?
95. Have there been any studies of the effectiveness of compulsory drug dependence treatment in the
country? What are the criteria of treatment effectiveness?

Overdose management
96. What laws/regulations/acts/instructions regulate the use of naloxone for overdose treatment? Can
naloxone be legally provided to drug users as a part of harm reduction programmes (for overdose pre-
vention) by the staff of outreach services?
97. Are there government-based or private programmes (shelters) that provide assistance to homeless
drug users?
Table 5. Types of drug dependence treatment

<table>
<thead>
<tr>
<th>Type of treatment</th>
<th>Availability (yes/no) and number of people on treatment</th>
<th>Type of medical facility (governmental or private facilities)</th>
<th>Form of treatment (out-patient or in-patient)</th>
<th>Availability in prisons</th>
</tr>
</thead>
<tbody>
<tr>
<td>Detoxification</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Use of opioid substances (opioid agonists) for detoxification</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>OST using methadone</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>OST using buprenorphine</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Take-away doses while on OST</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rehabilitation</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Counselling and psychosocial support</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>The “12 steps” method of recovery from drug dependence and similar programmes (e.g. Narcotics Anonymous)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other methods of treatment used for preventing relapse to drug use</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other methods of treatment directed at reduction of drug use or supervised consumption of drugs</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**HIV testing, treatment and support**

98. Is there a specific law on HIV in the country? (If yes, please enclose).
99. Does HIV legislation contain references to HIV prevention among injecting drug users? Are there any other provisions within national legislation that can be used as a legal basis for expansion of HIV prevention measures among risk groups?
100. Does HIV legislation include provisions on HIV prevention measures in prisons?
101. Is there free antiretroviral therapy for everybody in the country? Do people who use drugs and prisoners have access to antiretroviral therapy free of charge? If yes, please indicate the number of people who use drugs and the number of people in prison receiving antiretroviral treatment.
102. Is there a category of “socially significant diseases” or “socially dangerous diseases” within national legislation? If yes, which documents describe these definitions? Do these categories include such conditions as HIV infection, viral hepatitis, drug dependence, tuberculosis? What rights and limitations can be imposed by law upon persons with “socially significant/dangerous diseases”?
103. Is there education on HIV and drug use in schools? If yes, please describe which regulations confirm such provisions.
104. Are people living with HIV or those who use or have used drugs involved in HIV prevention work? Is there any legislation regulating such involvement?
105. Does national legislation contain provisions on involuntary HIV testing for the following categories of people: (a) military personnel; (b) public transport workers; (c) tourism and travel workers; (d) sex-workers; (e) others? Are there any provisions in national legislation on mandatory HIV testing when applying for a job, academic studies or social benefits?
106. Are there provisions in national legislation on informed consent to HIV testing? How is “informed consent” defined?
“informed consent” defined in national legislation? How is “informed consent” documented?

107. Is there pre- and post test counselling to accompany HIV testing? Who provides pre- and post-test counselling to the patients? Can NGOs provide HIV testing and counselling?

108. Is free and anonymous HIV testing available in the country?

109. Can HIV-positive status or drug dependence serve as a ground for forced abortion or sterilization?

110. Are there provisions on involuntary (compulsory and mandatory) HIV testing? Which categories of people are subject to involuntary HIV testing? Pursuant to which acts/instructions are such tests conducted? Please also describe which body or bodies can authorize compulsory HIV testing and the consequences of refusal to be tested. Please fill in the table below.

111. Which health care services related to HIV are free of charge and which are paid?

112. How is confidentiality of medical records protected? Who has access to medical records databases?

### Table 6: Categories of people subject to involuntary HIV testing

<table>
<thead>
<tr>
<th>Categories of people</th>
<th>Subject to involuntary testing or not</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>People who use drugs</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patients receiving drug dependence treatment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patients receiving tuberculosis treatment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patients receiving (viral) hepatitis treatment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patients with sexually transmitted infections</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prisoners</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sex workers</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Men who have sex with men</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Foreign citizens</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Immigrants</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Refugees</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pregnant women</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Newborns</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Orphans</td>
<td></td>
<td></td>
</tr>
<tr>
<td>State workers</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medical workers</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Law enforcement officers</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Military personnel</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Draftees (i.e., military conscripts)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Students (which professions?)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other categories of people (specify)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Patients’ rights

113. Does the Constitution of the country, or do other statutory and regulatory documents, mention patients’ rights? Are there provisions on the rights of patients in laws related to health care and rights of
consumers in the country? What rights are listed there?
114. Has the right to complain to higher authorities or to the court about the actions of administration of medical institutions been legally stipulated?
115. Are the following rights protected under national legislation of the country: (a) the right to the protection of private life; and (b) confidentiality of medical and private information, including information related to HIV? Are there any provisions on efficient protection of the confidentiality of patients' HIV status?
116. How are databases of AIDS centres maintained? How is confidentiality of information provided? What bodies or organizations have access to these databases?
117. What is the liability for failure to preserve a patient's confidentiality? Have any cases of such liability occurred in the past?
118. In what circumstances can a person's HIV status be disclosed without his/her consent (e.g. to public health agencies, to persons at risk of infection, to family members or sexual partners, to the law enforcement bodies and agencies, etc.)?
119. Is the right to voluntary withdrawal from treatment at any time provided in national legislation? Which categories of people are subject to compulsory treatment of HIV infection? What are the consequences of refusal of treatment?
120. Are there any obligations of citizens or non-citizens related to health (e.g. mandatory checkups)?

**Sterile syringe programmes**

121. Does legislation contain provisions on sterile needle and syringe programmes? If yes, what body is responsible for the development and implementation of such programmes?
122. Does the government provide sufficient funds for sterile needle and syringe programmes?
123. Does the law restrict pharmacy-based sales of syringes and needles (e.g. prohibition of distribution during the night time, prohibition of distribution to minors, or limited distribution for one person, etc.)?
124. Please describe provisions on the collection and disposal of used syringes.
125. How are records of clients maintained in sterile needle and syringe programmes? How is the confidentiality of information respected in such programmes?
126. What laws and regulations might hamper the work of sterile needle and syringe programmes?
127. Can people who use drugs be involved in the work of sterile needle and syringe programmes (e.g., as peer counsellors and outreach workers)?
128. Please describe the functions of outreach workers (e.g. distribution of information about HIV and AIDS and drug dependence treatment, referral to medical facilities, social and legal aid, assistance in housing and responding to overdoses).
129. How does national legislation regulate outreach services? Are staff members and volunteers of outreach services exempted from potential criminal or administrative liability for outreach work?
130. Other harm reduction services: Are there provisions in national legislation enabling existence of facilities for supervised drug consumption? If not, can national legislation be interpreted to allow such existence?

**Groups with specific needs**

**Women**

131. What legal provisions or factors might hamper access of women to drug dependence treatment in the country (e.g., lack or absence of medical facilities for women, fear of losing parental rights if admitting to drug use)? Please conduct interviews with persons working in this field
132. Please compare the documented or estimated number of women who use drugs to the number of men who use drugs.
133. How many programmes/wards are there for women in drug dependence treatment centres? Can women be together with their children while in treatment?
134. Do harm reduction programmes distribute information specifically designed for women? Do they also have specific services for women?
135. What are the legal grounds for limiting parental rights? Can drug dependence or HIV-positive status affect parental rights or guardianship?
136. Can drug use or HIV infection be a barrier to adoption of children?
137. Where do orphans tested HIV-positive or children of people with HIV live? Do orphans with HIV live in general orphanages or in specialized orphanages?

Sex workers
138. How does national legislation define prostitution/sex work and related activities that may be addressed in criminal or administrative codes (e.g., procuring, organization of premises, communicating for the purpose of prostitution)?
139. What HIV prevention measures are aimed at sex workers? Do NGOs or the government implement HIV prevention measures for sex workers (e.g., distribution of condoms, syringes, information on HIV prevention)?
140. Are there any provisions authorizing compulsory STI or HIV tests or treatment for sex workers?

Youth and students
141. Is there any restriction on the sale or possession of condoms? Can minors purchase condoms?
142. Can minors use sterile needle and syringe programmes? Can minors purchase a syringe in pharmacies?
143. Can minors be subject to compulsory treatment for drug dependence, STIs or HIV infection?
144. Is there compulsory testing on drug use and HIV in educational institutions? Will a minor’s parents be informed in the case of positive test results? What are the consequences of refusing HIV testing?

Migrants
145. Do immigrants and refugees have access to health care and HIV prevention programmes?
146. Is there compulsory HIV testing for foreigners? What is the procedure of HIV testing for this category of people? Describe the consequences of HIV-positive status for foreign citizens and the consequences of refusing to take an HIV test.

VI. Prisons

Background information and statistics
Please indicate the following information (including the source and year of statistical information):
(a) Prison system: number of prisons in the country, their security level and occupancy rate.
(b) Prison population statistics. Indicate as well the percentage of people held for drug offenses (for non-violent and minor crimes) and the security level of prisons in which they are held.
(c) Statistics on the prevalence of HIV infection, viral hepatitis and tuberculosis in prisons. Statistics on drug use (including injecting drug use) in prisons.
147. Please describe the system of subordination of correction departments and agencies.
148. Please describe subordination of health facilities in prisons. Which agency/department is responsible for providing health care in prisons or pre-trial detention centres?
149. Are there working groups/committees on HIV in prisons?
150. Please describe programmes and strategies on HIV-related health disorders in prisons. Are there provisions on HIV prevention, including prevention of transmission via injection?
151. Are there mechanisms for involving NGOs in HIV prevention work in prisons?
152. Please indicate the number of people under house arrest (if applicable), people conditionally discharged from a penalty and people serving non-custodial sentences for drug related offences.
153. Can a person who committed a crime be discharged from criminal liability due to illness?
154. Can a national court mitigate a person’s sentence or discharge him or her from a sentence for drug-related crimes based on the person’s illness? If yes, how often is such mitigation of penalty applied by courts?
155. Can medical parole be used as an excuse to discharge someone from a prison sentence before the sentence is completed? Are prisoners with HIV entitled for medical parole? Please indicate relevant national legislation.
156. Can prisoners sentenced for drug-related crimes be eligible for conditional early release, transfers to prisons with lower security level or substitution of the remaining term with a more lenient one (due to
acts of amnesty, or for good behaviour and etc.?)?
157. What crimes related to drugs require pre-trial detention?
158. Please describe the national legislation regulating pre-trial detention. How often is pre-trial detention applied in drug-related cases?
159. What is the maximum duration of pre-trial detention?

Health care in prisons

160. Do medical facilities in prisons have adequate supplies of medical equipment and medication? (Please make sure to interview current or former prisoners.)
161. Is health care in prisons equivalent to health care for the general population?
162. Have there been any cases of refusal to provide treatment in prisons? Can such refusal be reviewed by a court or tribunal?
163. Is specialized clinical treatment (e.g. for HIV infection) available in prisons?
164. In cases where necessary medical care is not available in prisons, is it possible for prisoners to receive such care outside of prison?
165. Is there a document regulating HIV prevention services and programmes in prisons?
166. How is the confidentiality of medical records protected in prisons? Are there special rules guaranteeing that prisoners' files are not marked in a way that discloses their HIV status?
167. Are there rules aimed at protecting prisoners with HIV from segregation/isolation or any other measures that might disclose their status?
168. Please describe conditions of people tested HIV-positive who are held in prisons. Do prisoners with HIV have any special conditions while serving their penalty?
169. Are prisoners with HIV or tuberculosis held separately from other prisoners? What categories of prisoners are held separately from other prisoners?
170. Is antiretroviral therapy available for people with HIV in prisons?
171. Is treatment for tuberculosis and viral hepatitis B and C available in prisons?
172. Is voluntary drug dependence treatment available in prisons? If yes, what forms of treatment are available?
173. Can prisoners be subject to compulsory treatments (e.g. for drug dependence, HIV-infection, STIs, etc.)? If yes, please include statistical numbers and effectiveness of such treatment (if applicable), especially related to compulsory drug dependence treatment.
174. Are there specialized medical facilities for prisoners with drug and alcohol dependence within the Ministry of Justice or Ministry of Interior? Which documents regulate sentences served in such facilities?
175. What agency has authority to make decision about compulsory treatment for drug dependence in prisons? What documents regulate such treatment?
176. Please describe the duration, procedures and types of compulsory treatment in prisons.
177. Does compulsory treatment for drug dependence affect other rights of prisoners?
178. Are prisoners on compulsory treatment for drug dependence eligible for transfer to facilities with better conditions?
179. What might be the consequences of refusal of compulsory drug dependence treatment?
180. What happens if a prisoner is not able to finish compulsory drug dependence treatment by the time of release from the penitentiary?
181. Can people continue treatment (e.g. for drug dependence, HIV-infection or viral hepatitis) started in the prison after their release from the institution without any interruption? How is this issue regulated? How is information exchanged between the prison and public medical institutions?
182. Is OST available in prisons? Please indicate national legislation that allows for OST in prisons (or can be interpreted as permitting it).
183. Please describe OST or other new programmes of drug dependence treatment in prisons.

HIV-infection and STI

184. Is there compulsory HIV testing for prisoners? If not, are there regulations prohibiting compulsory HIV testing for prisoners?
185. If compulsory HIV testing in prisons exists, is pre- and post-test counselling provided in such cases?
186. Are there regulations on obtaining informed consent for HIV testing before the testing (voluntary testing)? Is counselling provided before and after test?
187. Are there regulations prohibiting compulsory drug use tests for prisoners?
188. Do prisoners with HIV, drug dependence or viral hepatitis have special conditions of employment in prisons? Are there regulations providing employment of prisoners according to their health conditions?

HIV prevention in prisons

189. Is information on HIV transmission and its prevention available in pre-trial detention centres and prisons? If yes, what normative acts regulate such distribution of information? What measures on HIV prevention are conducted by the governmental bodies and agencies in prisons?
190. Can prisoners participate in HIV preventive measures as peer counselors?
191. What HIV preventive measures are provided in prisons? Please fill in the table below. What normative acts regulate HIV prevention measures in prisons?
192. If there is not any regulation that legalizes HIV prevention measures in prisons, can provisions of national legislation be interpreted so as to allow such measures in prisons?
193. Is sterile injection equipment available in prisons? If yes, what regulations legalize availability of such equipment in prisons?
194. Do prisoners have free access to products of personal hygiene (including personal shaver)?
195. Do prisoners have access to sterile tattoo equipment? If yes, what regulations legalize such access?
196. Do prisoners have access to condoms (not only in conjugal visits rooms)?
197. Do prisoners have access to disinfectants?
198. What items are listed as not allowed to possess (for example, the items used for cutting or piercing, watches and etc.)?
199. Are there provisions in national legislation guaranteeing that the prisoners living with HIV are not precluded from participation in the various programmes, activities, entertainment and social events in the prison due to their HIV status?
200. Are there regulations admitting the existence of sexual contacts based on mutual consent in prisons and guaranteeing that such sexual contacts are not a subject to punishment?
201. Are there special provisions regarding protection of prisoners from sexual violence?
202. Is food, clothing, everyday necessity goods and personal hygiene items provided to prisoners free of charge or for money? If these products provided on paid basis, what happens if a prisoner is unable to pay?
203. Can prisoners buy grocery products without limitation on their own money?
204. Do prisoners with HIV have access to improved meal plans in case if they do not have financial means to buy extra grocery products? Are prisoners with HIV allowed to receive additional parcels?
205. Please describe conditions of prisoners with TB held in prisons? Where prisoners with TB get their treatment: in the specialized wards of the health unit or in general hospital?
206. In what cases the prisoners are placed under quarantine (isolation)? Can prisoners with HIV and TB be placed under quarantine (isolation)?
207. Are there provisions in national legislation that legalize distribution of following items or conduct of following measures in prisons:
   a) information on HIV;
   b) condoms;
   c) disinfectants;
   d) sterile needles and syringes;
   e) disposable shaving accessories and other items of personal hygiene;
   f) voluntary HIV testing with counselling;
   i) OST;
   h) other HIV prevention measures.
208. What is included in educational work with prisoners (please include reference to the provisions on national legislation)? Is information on health care and HIV included in such education?
209. Are there pre- and post-release rehabilitation programmes for prisoners? What documents regulate such rehabilitation programmes? What is the main aim of rehabilitation programmes? Do such rehabilitation programmes include assistance to prisoners in employment, housing, adaptation? Do rehabilitation
programmes include social rehabilitation of people who use drugs?

210. Are there any regulatory acts, programmes prohibiting discrimination and stigma based on HIV status in prisons?

211. Are there regular, free programmes on tolerance and HIV prevention education for prisons’ staff (issues of discrimination based on HIV status, HIV preventive measures among prisoners, confidentiality of medical records and HIV status of prisoners, homophobia, humane treatment and etc.)

212. Are there specialized prisons for minors? What are conditions of holding minors with HIV in prisons?

213. If there is compulsory medical treatment for minors in prisons, how such treatment is provided?

214. Are there provisions in national legislation regulating distribution of information on HIV in special prison facilities for minors?

215. Are there any particular provisions/regulations related to special needs of women-prisoners as regards their health in general, prevention of STIs, HIV and HCV and drug dependence treatment? Please list them.

216. Which laws and regulations (or their interpretations) have potential to hamper HIV prevention measures in prisons?

217. Are there laws or regulations providing independent monitoring of prison management and respect for prisoners’ rights, including the rights of those with HIV and drug dependence?

Table 7. Medical services in prisons and pre-trial detention centres

<table>
<thead>
<tr>
<th>Services</th>
<th>Antiretroviral therapy</th>
<th>Prevention, diagnostics and treatment of TB</th>
<th>Prevention, diagnostics and treatment of other STIs</th>
<th>Prevention, diagnostics and treatment of viral hepatitis B and C</th>
<th>Prevention, diagnostics and treatment of drug dependence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Availability for general population</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Availability in pre-trial detention facilities</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Availability in prisons</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Possibility to continue the treatment started before imprisonment</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Possibility to continue uninterrupted treatment after release</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Comments</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Table 8. HIV prevention and care programmes in prisons and pre-trial detention centres

<table>
<thead>
<tr>
<th>HIV prevention measures</th>
<th>Availability in prisons (yes or no)</th>
<th>Availability in pre-trial detention centres</th>
<th>Accessibility (including the body or agency that provides the services)</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Distribution of information related to HIV transmission and its prevention</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Distribution of condoms</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
VII. Anti-discrimination provisions

218. How does national legislation prohibit discrimination? Does national legislation contain such concepts as direct and indirect discrimination? Have there been any legal cases on discrimination related to HIV-infection or drug dependence (or health status in general)?

219. Is discrimination against people living with HIV and people who use drugs explicitly prohibited under the laws of the country?

220. How does national legislation define “disability”? Does the concept of disability include HIV-infection and drug dependence?

221. What are the mechanisms for obtaining compensation in cases on discrimination? Has there ever been such case?

222. What bodies or agencies are responsible for protection against discrimination?

223. What laws and regulations (including national programmes and acts of the executive bodies) can have a serious impact on the risk of discrimination or stigmatization of drug users or prisoners?

224. Are there any provisions in national legislation against promoting negative images of drug users?

225. Are there organizations of people who use (or have used) drugs?

226. Describe (and enclose) normative acts that can have impact on the capacity of NGOs to work in the field of HIV-infection and drug use in prisons.
APPENDIX 3: TRAINING MODULE

Contents

• Introduction
• Training goal
• Basic methodology

IV. Methodical recommendations on delivering training material
V. Training modules:

2 Model Law on Drug Use and HIV/AIDS and Assessment Tool.
3 Human rights and harm reduction.
4 Administrative and criminal law and international drug control conventions.
5 Health care services, treatment of HIV infection and drug dependence treatment.
6 Specific harm reduction measures: sterile needle and syringe programmes and supervised drug consumption facilities.
7 Prisons.
8 Anti-discriminatory provisions and increased involvement of people living with HIV and people who use drugs in decision making.
9 Planning activities for legislative review, assessment and reform

VI. Information for trainers

Annex A. List of documents used in training
Annex B. Sample training programme
Annex C. Legislative analysis exercise
Annex D. Evaluation of training session: participant questionnaire
I. Introduction

One of the tasks of the project entitled Effective HIV prevention and care for vulnerable populations in Central Asia and Azerbaijan (2006-2010), implemented by the United Nations Office on Drugs and Crime (UNODC), was to provide support to the six participating countries in their work on upgrading national legislation, provisions and standards related to HIV infection, drug use and prisons, in alignment with the relevant UN documents. For this purpose, as described earlier, each of these countries formed a group of experts who analysed and assessed legislation using methods developed by the Canadian HIV/AIDS Legal Network to determine whether or not their legislation adequately provided for accessibility of services for prevention of HIV infection and care for people who use drugs and for prisoners.

To familiarise the experts taking part in the project with international human rights standards, legal principles of HIV prevention and treatment, and general accessibility of health care services for people who use drugs and people in prisons, a five-day training session was held in 2007 at the very start of the project. These training guidelines include basic information presented during that training, as well the teaching methods. The guidelines are aimed to inform interested individuals about the project's methodology and to facilitate implementation of similar projects in the future. Designed for trainers, the guidelines represent a thorough and detailed training scheme on the human rights standards and assessment methods of HIV prevention and treatment regulation in the national legislation.

II. Training goals

The training took place within the framework of technical assistance to the countries in their work on upgrading national legislation and regulatory documents to remove legal barriers hindering access to HIV prevention and treatment services for people who use drugs and for prisoners. The ultimate goal of the review and assessment of legislation was the development of recommendations for proposing amendments to the relevant laws, bylaws and other regulatory documents, and ensuring approval of these amendments by corresponding national structures.

This training was designed for participants representing a multidisciplinary group of experts working in law-enforcement, corrections, public health and other areas dealing with HIV issues. It was expected that at the end of training the participants would:

- improve their knowledge of international human rights standards related to HIV prevention and treatment for prisoners and people who use drugs;
- familiarize themselves with the contents of the Model Law on Drugs and HIV/AIDS (2006), developed by the Canadian HIV/AIDS Legal Network as a guideline for future legislative reforms;
- gain knowledge and skills for using the Assessment Tool to review national laws and strategic documents related to providing access to HIV prevention and treatment services for prisoners and people who use drugs;
- prepare (or improve) the initial plan and work schedule for reviewing and realigning the national legislation and developing recommendations for its amendment.

III. Basic methodology

How to use these guidelines:

These guidelines are designed as a handbook for those who want to replicate the UNODC's project on assessment of legislation and bylaws related to the issue of accessibility of HIV prevention and care services for prisoners and people who use drugs. These guidelines and the principles used for the structured assessment of legislation can also be used by specialists from other areas related to HIV prevention and care among other population groups. Similar assessment and analysis of legislation and law implementation can be used as a first step towards changing policy and law practices in one or another area. Naturally, in that case, it will be necessary to adapt the training contents and the Assessment Tool.

The structure of the guidelines:

A 5-day training course consists of 8 modules. The modules are structured so that, at the beginning, par-
Participants learn general principles and paradigms, such as human rights (specifically the right to health), drug control policies, and the need to ensure health care for prisoners. This is followed by the discussion of scientifically justified approaches to HIV prevention and treatment through the concept of universal access to HIV prevention and treatment services with the focus on the rights and needs of people who use drugs and of prisoners. Such a structure lays the groundwork for the philosophy of further assessment of legislation; specifically it includes identification of legal obstacles preventing access to health care services and social support, which are crucial for efficient HIV prevention and treatment among people who use drugs and people in prisons. A special session is devoted to the usage (and possible adaptation) of the Assessment Tool, which should act as a guideline for experts in their assessment of national legislation.

Each training module comprises a training plan, goals and methods of training, and provides an outline for presentations and recommended exercises and group work. The training sessions consist of presentations and group work. If adapted, the training programme should be optimized for maximum interaction and engagement. Participants should not only gain new knowledge and information about the law, human rights, and HIV prevention and treatment, but also learn to use the acquired knowledge and skills in the process of legislation analysis and the development of a strategic plan for legislative reforms.

Training participants might differ by professional status and previous work experience. Among them there could be lawyers working at state agencies, workers of the prosecutor’s office, representatives from law enforcement, correctional institutions, drug control agencies, health care institutions and NGOs. In general, the participants may have legal knowledge, but they might lack adequate experience in using the law in the issues related to HIV prevention and treatment; they may be unfamiliar with the principles and methods of effective evidence-based interventions and may have wrong ideas about the concept of harm reduction related to drug use. Ideally, they would be united in their interest in international law, human rights, issues of humanization of criminal law (with regard to people who use drugs), and penitentiary system reform, including other countries’ experiences.

Trainers providing this training should be lawyers with adequate knowledge regarding:
- international law and human rights principles, including the right to health;
- international standards regulating drug control issues;
- UN legal principles related to prisons and other closed settings;
- law enforcement issues in relation to human rights of people who use drugs and of prisoners, including the right to accessibility of effective health care services for HIV prevention and treatment; and
- evidence-based interventions for the prevention and treatment of HIV and drug dependence.

It is recommended to include trainers from NGOs who have direct work experience with prisoners and people who use drugs, as well as staff of international organizations and UN agencies working in the area of HIV and drug use. It is also recommended to involve representatives from state organisations and lawmakers, as it may be exactly these people who will be directly involved in the legislative reform process — from initiation to acceptance of amendments to the laws and/or drafting new laws. It is preferable to have a trainer who is knowledgeable in medicine and drug control policies, who can inform trainees about the difficulties and obstacles that people who use drugs might encounter in accessing HIV prevention and treatment services.

It is recommended to invite representatives from NGOs and communities of people living with HIV, people who use drugs and former prisoners to meet with the trainees and provide first-hand and more comprehensive accounts of the needs and the problems they encounter in getting access to HIV prevention and treatment. These meetings can be scheduled on the third and/or fourth day of training and should include adequate time for questions and discussion.

The essence of this training is interactive learning. Trainers should use various methods and techniques, including brainstorming, discussions, problem-solving exercises (based on specific legislation in the studied area), and group work. The trainers can provide participants materials for independent work, particularly texts of international conventions on drugs; agreements in the area of human rights; international recommendations for HIV and AIDS prevention and treatment for people in prisons and people who use drugs.
drugs; as well as excerpts from the relevant legislative acts. (A list of handouts and exercise examples and are shown in Annexes A and C of this Module).

When planning presentations, it is important to allocate sufficient time for questions and answers. The training includes an exercise, which is given in Annex C of this Module. There are also three or four sessions of group work during which the participants discuss new information and learn how to apply the knowledge they gained during the training.

It is expected that by the end of training the participants will be able to assess the legislation and bylaws of their countries using the Assessment Tool, write a report and formulate recommendations on the improvement of legislation introducing changes or amendments into legislative and other regulatory documents.

**Equipment for training:**
- Laptop computer;
- USB memory sticks;
- Flip charts;
- Highlighters, markers; and
- LCD projector.

**IV. Methodical recommendations on conducting the training**

**Introduction of participants and their expectations:**
At the beginning, it is important to give the participants an opportunity to get acquainted with each other and to create a friendly atmosphere in the group. For this purpose, the trainer should ask the participants to introduce themselves and speak about their expectations about the training. This will allow the participants to better acknowledge their own goals and see how these concur with the interests of other participants. This will also help the trainer to understand what he/she should focus on during the training. It is recommended to write down the expectations of every participant so that at the end of the training the participants can perform a self-assessment and decide if their expectations were met. It is supposed that participants should be able to identify the general goal of the training — gaining knowledge and skills for assessment of national legislation using standard tools; identification of provisions hindering universal access to HIV prevention and treatment for prisoners and people who use drugs; and laying down recommendations for legislative reform.

**If the training is conducted for representatives from different countries** with different national legal systems, the presented information should not focus on the specifics of national legal systems. Instead, attention should be paid to international law, specifically human rights instruments and principles and the conventions on drug control. The participants should learn positive experiences of countries that successfully regulate various issues related to prevention and treatment of drug dependence and HIV-infection and provide for accessibility of health care services in prisons.

If the training is conducted for an international group of experts, it might include presentations by national teams in the situations in their own countries. For this purpose, it is recommended to ask national teams in advance to prepare 15–20 minute presentations covering the following subjects: national legislation and law enforcement in the area of drug abuse; legislation in the area of drug dependence treatment; accessibility of health care services in prisons; legislative regulation of harm reduction; and possible obstacles to effective HIV prevention and treatment for vulnerable populations.

**If the training is conducted for representatives from one country,** it is necessary to invite national lawyers (defence lawyers) who have practical experience in dealing with human rights, working with people who use drugs, and handling cases involving drugs. If possible, it is recommended to invite lawyers from NGOs working in the harm reduction area or providing legal assistance to people living with HIV and to people who use drugs. This will provide the participants with insight into the national legislative system and how laws are implemented/enforced in relation to crimes involving drugs and criminal prosecution of people who use drugs.
Sample of training plan on national legislation:

<table>
<thead>
<tr>
<th>Day</th>
<th>Subject</th>
<th>Recommendations</th>
</tr>
</thead>
<tbody>
<tr>
<td>3</td>
<td>Administrative and criminal law</td>
<td>Examine the basics of administrative and criminal law and law enforcement practices in the area of drug use, drug possession, incitement of drug use and drug propaganda. The trainer should pay attention to practical aspects.</td>
</tr>
<tr>
<td>4</td>
<td>Health law / right to health</td>
<td>Health law practices; legal aspects of drug dependence treatment, including therapy by opiate agonists (substitution therapy – OST); patients’ rights; liability in case of medical service denial; liability in case of infecting or putting other people into a risk of HIV-infection; legal background of involuntary/compulsory treatment. The trainer should speak about whether or not there were instances of criminal cases or criminal procedures initiated in the mentioned areas.</td>
</tr>
<tr>
<td>5</td>
<td>Issues related to protection of people who use drugs and people living with HIV</td>
<td>Law and law implementation practices in the area of protection against discrimination. Issues related to the attitudes of law enforcement bodies, judges and prosecutors.</td>
</tr>
</tbody>
</table>

These training sessions should be based on the law implementation practices and include detailed review of the issues mentioned above. It is important to remember that among training participants there might be many lawyers who do not need theoretical basics of the problems discussed. They might be mostly interested in the nuances of law enforcement practices and in the question to what extent existing legislation can obstruct (or facilitate) successful HIV prevention and treatment among prisoners and people who use drugs.

If the majority of participants are NGO workers or specialists in other areas, the training organisers should change the structure of training in accordance with the needs of participants. In other words, if there are many NGO representatives (who most likely are not lawyers), it is advisable to provide more information about legal aspects and about national legal systems, and less information about practical aspects of harm reduction and HIV-related issues.

V. Training modules

Recommended structure of each module:
1. Introduction
2. Presentations, questions and answers and
3. Exercises, group work, discussions.

This training is based on the Model Law on Drug Use and HIV/AIDS (www.aidslaw.ca/modellaw) and developed in accordance with the Assessment Tool structure, designed for assessment of legislation and law enforcement practices. For effective time management and for better structuring of presented materials, the training modules do not exactly follow the order of the the Model Law modules. Some of the Model Law modules were not included in the training materials and some were incorporated in other materials. However, we recommend the trainers study thoroughly the Model Law and the Assessment Tool.

<table>
<thead>
<tr>
<th>Day</th>
<th>Module</th>
<th>Structure</th>
<th>Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Day 1</td>
<td>Module 1: Model Law and the Assessment Tool</td>
<td>1. Presentation: Model Law on Drug Use and HIV/AIDS. International experience&lt;sup&gt;1392&lt;/sup&gt;</td>
<td>1 hour</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2. Presentation: Assessment Tool for assessing legislation and law enforcement practices</td>
<td>40 min</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Independent work: familiarisation with the Assessment Tool and the Model Law on Drug Use and HIV/AIDS</td>
<td>50 min</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Total time:</td>
<td>2 hours 30 min</td>
</tr>
</tbody>
</table>

<sup>1392</sup> Time includes question and answer section.
<table>
<thead>
<tr>
<th>Day</th>
<th>Module</th>
<th>Contents</th>
<th>Time</th>
</tr>
</thead>
</table>
| Day 1 | Module 2: Human rights standards and harm reduction concept | 1. Presentation: What is harm reduction?  
2. Presentation: Human rights and drug control policy  
Discussion: Obstacles for practical implementation of the human rights-based approaches in HIV prevention and treatment among vulnerable populations | 1 hour |
| Day 2 | Module 3: Criminal law issues and international conventions on drugs | 1. UN Conventions on drugs  
2. Administrative and criminal law issues  
3. Exercise: Analysis of hypothetical legislation (see the Annex) | 30 hour |
| Day 2-3| Module 4: Drug dependence treatment and other health care services | 1. Presentation: Models of drug dependence, principles of organization of drug dependence treatment and human rights standards  
Group work on Assessment Tool | 1.5 hours |
| Day 3 | Module 5: Syringe and needle exchange programmes and premises for supervised drug use | 1. Programmes providing sterile syringes and needles  
2. Rooms for supervised drug use  
Discussion: Moral aspects or human rights principles and evidence of effectiveness | 40 min |
| Day 4 | Module 6: Prisons | Presentation: Health care standards ensuring equality within the correctional system  
Group work. Task: a) identify 2–3 most serious obstacles for initiating or expanding one of the effective interventions on HIV prevention in prisons; b) suggest 2–3 strategies to overcome these obstacles | 1 hour 20 min |
| Day 4 | Module 7: Protection from discrimination and greater participation of people living with HIV and people who use drugs in decision making | Presentation: Protection from discrimination and greater participation. Outreach work  
Discussion with participation of people living with HIV, people using drugs and NGO representatives who work in the field of harm reduction. They should be asked to speak about the real difficulties in getting access to HIV prevention and treatment and discuss in the group ways to overcome these obstacles. | 1 hour |
| Day 5 | Module 8: Group work: development of a work plan for legislation assessment and priorities setting | Total time: depending on the need. | 2 hours. |
MODULE 1: Model Law and the Assessment Tool
The first module should introduce the Model Law to the participants and give directions on its use for assessing national legislation and law enforcement practices, and their compliance with international human rights standards; the module should also familiarise the participants with the Assessment Tool.

Presentation 1: Model Law
For this presentation the trainer must thoroughly study the Model Law. The presentation should cover the Model Law provisions and, if possible, some national law provisions to give the participants an idea about effective regulation of issues related to HIV prevention among people who use drugs in other countries.

Presentation 2: Assessment Tool
In this presentation the trainer should speak about the purpose of the Assessment Tool, its structure and the aspects that should be considered in completing the Assessment Tool.
1. Structure of the Assessment Tool.
2. How to identify legislative reform priorities for each specific country using the Assessment Tool.
3. Recommendations on filling in the Assessment Tool; what documents should be included; and who should be interviewed.
5. Continuation of work: working with policy makers and informing about the results of legislation assessment.

Task: Study the Assessment Tool and prepare questions

MODULE 2: Human rights standards and harm reduction
This module should introduce the participants to the following issues: what is harm reduction; what is the correlation between harm reduction and human rights; what is the position of international organisations and UN agencies with regard to these issues; and how law regulates the issues of harm reduction and human rights. If the training is intended for participants from the same country, it is necessary to cover the issues of legal regulation of harm reduction programmes within national legislation. It is also necessary to introduce participants to drug control policy that is human rights-based and scientifically justified, as well as HIV prevention-oriented.

For this purpose, in this module we recommend giving two presentations accompanied by discussions.

Recommended issues for presentation 1: “What is harm reduction?”:
1. The concept, definition and philosophy of harm reduction related to drug use;
2. Types of interventions included in harm reduction:
   - Programmes providing sterile syringes and needles;
   - OST;
   - Distribution of condoms;
   - Distribution of disinfection materials;
   - Other.
3. Countries using harm reduction approaches.
4. Harm reduction issues in the region and legal regulation of harm reduction in the national legislation.
5. Harm reduction in prisons.

It is recommended to adjust the details of information covered in this presentation to the participant’s goals of the training and participants’ level of knowledge of this subject.

Recommended issues for presentation 2: Human rights and drug control policy:
1. Efficient drug control and HIV prevention policy: In this presentation it is recommended to mention the ineffectiveness of an exclusively criminal law approach to the problem of drug abuse and to stress the
need to find balance between law enforcement measures and approaches guaranteeing improvement of health status of the population (approaches based on health care priorities).

2. Human rights, right to health and international documents regulating right to health.

3. If participants represent one country, discuss the issues of public health legislation, the basics of the Health Law and precedents in this area for that country.


**Discussion**: Obstacles for implementation of human rights-based approaches to HIV prevention among vulnerable populations. The Moderator should start this discussion by asking for ideas on the possibility of introducing harm reduction measures through regulation of these issues in the national legislation, and about the obstacles that might occur in this process.

---

**MODULE 3: International drug conventions and criminal law issues**

In this module the participants should learn about the international conventions on drugs and the impact of these documents on national legislation with regard to drug-related crimes. We recommend the trainers thoroughly study Module 1 of the *Model Law on Drug use and HIV/AIDS* and all three UN conventions on drugs.

Recommended issues for presentation **1: UN drug conventions**:

1. UN conventions on drugs
2. Legal interpretation: flexibility of the conventions’ provisions

Recommended issues for presentation **2: Administrative and criminal law provisions**:

1. Deficiencies of an exclusively criminal law-based approach in the issues of drug abuse.
3. Humanisation potentials:
   - Alternatives to criminal prosecution
   - Alternatives to imprisonment
4. Examples from the Model Law and other countries’ legislative acts

**Exercise**:

At the end of this module the participants should be asked to conduct an analysis of the hypothetical legislation. The exercise is based on real country legislations from around the world. The participants should analyse and provide an assessment of the clauses/articles as of their impact on the effectiveness of HIV prevention and public health in general. The legislative provisions in this exercise are taken from the laws of the Russian Federation, Canada, the United States of America and Belarus (see an example of this exercise in the Annex of these Guidelines).

---

**MODULE 4: Drug dependence treatment and HIV prevention**

At the beginning of this module the facilitator can briefly repeat the information about the right to health, *International Pact on Economic, Social and Cultural Rights*, and the right to medical services, including drug dependence treatment services stemming from the right to health. In this module it is necessary to give a detailed review of the following issues: drug dependence treatment standards; patients’ right to participate in decision-making regarding their treatment and their right to influence the treatment process; treatment methods such as use of long-acting opiate-agonists (or opiate substitution therapy — OST); OST procedures and standards; and importance of OST in HIV prevention among people dependent on opiates.

If the training participants represent one country, it is important to review the drug dependence treatment standards in that country as well as the procedures and rules of providing OST (including OST accessibility and its coverage).

**Plan of the presentations**:

1) What ways human rights standards, especially those related to the right to health, can be applied in the field of drug dependence treatment.
2) How to measure OST accessibility and treatment quality (service provision standards and clinical protocols). For participants from countries without legal provisions for OST, it is important to draw their attention to the fact that UN agencies recommend OST as one of the most effective measures of HIV prevention and treatment of opiate drug dependence. It is recommended to provide a review of other countries’ legal regulations about OST accessibility.

3) Other methods and standards of drug dependence treatment; legal regulation of these methods and standards.

**Group work on the Assessment Tool:**
In this exercise the participants break into thematic groups to discuss various issues related to the Assessment Tool, e.g. access to medical services. The groups should discuss the following issues: a) what documents should be included in the assessment; b) what groups of people should be interviewed for obtaining additional information; c) what issues require special attention.

**MODULE 5: Needle and syringe programmes and supervised drug consumption facilities**
This module covers two types of harm reduction interventions. The most popular and widely employed harm reduction method is the provision of sterile syringes and needles. The premises or institutions for supervised drug consumption are less widely employed, but according to the statements of international organisations, they do not contradict international law or standards.

**Presentation 1: Sterile needle and syringe programmes**
2. International documents legalising programmes providing sterile injection instruments. Regulation of the programmes providing sterile injection instruments in the national legislation (if the training is conducted for representatives from a single country).

**Presentation 2: Supervised drug consumption facilities**
1. Importance of availability of supervised drug consumption facilities.
2. International documents on legality of these institutions.
3. Model Law Module 4 on supervised drug consumption facilities.

The information provided should introduce participants to large-scale HIV prevention strategies for people who inject drugs. Supervised drug consumption facilities exist in a number of countries; however this approach is still controversial. This training recommends introduction of such strategies only with careful consideration of the specific political and social environment in the country in question.

**Discussion:** Harm reduction: “Moral” considerations vs. human rights principles and the evidentiary effectiveness.

The discussion can begin from a review of such a controversial approach as an opening of safe drug use facilities. In many countries, there are people who believe that intimidation and punishment are effective means of decreasing drug use levels and consequently the risk of HIV-infection. This approach implies the requirement of immediate termination of illegal drug use. How realistic are these requirements? According to WHO, drug dependence is a chronic disease, and people who use drugs should not be automatically counted as offenders who lose their rights — they have the same rights and protections as everybody else. It is necessary to stress not only the human rights component but also the public health aspects of this issue. To what extent does the current prohibitionist policy towards people who use drugs promote public health and social well being? Is it effective?

**MODULE 6: HIV prevention and treatment in the correctional system**
This module is designed to introduce participants to the HIV prevention and treatment measures in the correctional institutions. The details of this presentation can vary depending on the participants’ knowledge level and their interests. The concept of “prisons” in this document embraces all institutions of the correctional system, including colonies and temporary detention centres.
Plan of the presentation:
1. The risk of HIV-infection spread in prisons: Why is it important to introduce harm reduction approaches in prisons?
2. Rights of prisoners: Prisoners and people detained in temporary detention centres are deprived of freedom while enjoying all other rights. They must have access to the same level of medical care available to the general population.
4. Prevention of HIV-infection and associated diseases at correctional institutions.

If the training participants represent a single country, it is recommended to familiarise them with the situation related to HIV-infection prevalence and the approaches to prevention of HIV-infection and associated diseases within that country’s correctional system.

Group work: The participants break into 6 groups. The theme of discussion: “Health care in prisons: legal and regulatory aspects.”
Task: a) define 2–3 of the most serious obstacles for initiating or increasing the scale of one of the six effective interventions (below) on HIV-infection prevention in prisons; b) offer 2–3 strategies that will help to overcome these obstacles.
Thematic groups: 1) Syringe distribution/exchange programmes; 2) Opiate substitution therapy and other drug dependence treatment methods; 3) STIs and condoms; 4) Voluntary counselling and HIV testing; 5) treatment and support of people living with HIV; 5) Viral hepatitis and TB; 6) Prevention of violence, especially as regards sexual violence.

MODULE 7: Protection against discrimination and greater participation in decision making of people living with HIV and people who use drugs
In this module’s presentation it is recommended to discuss an important issue of human rights guarantees, for example, protection against discrimination. Discrimination against people living with HIV and people who use drugs manifests in different ways (provide the definitions of discrimination and stigmatization and provide examples). The theme of greater participation in decision making of people living with HIV and people who use drugs is integrated with the theme of protection against discrimination, because participation is one of our human rights and a form of self-protection of one’s own rights. In this module it is also necessary to discuss the theme of outreach work conducted by former or current drug users and to stress the greater effectiveness of such work versus similar activity conducted by medical workers or people who do not have personal experience in drug use.

Presentation:
1. The concepts of discrimination, vilification and stigma.
2. How to address discrimination and stigmatization. UN documents and legal protections.
3. Greater involvement of people living with HIV and people who use drugs in decision making.
4. Outreach work.

Discussion with the participation of people living with HIV, people who use drugs, and NGO representatives active in the area of harm reduction. Encourage them to speak about real life difficulties in accessing HIV prevention and treatment services that they encounter and discuss the ways for overcoming these obstacles.

MODULE 8: Planning activities for legislative review, assessment and reform
On the last day of training it is recommended to work in small groups to plan further activities for improving access to HIV prevention and treatment services for prisoners and people who use drugs. The group work should focus on reaching the final goal of the training. It should be based on the participants’ expectations. If the final goal of the training includes legislation assessment (as in the case presented in these guidelines), it is necessary to plan on the last day the activities for reaching this goal. If the final goal is different, then it is necessary to plan the activities in accordance with that goal (creation of a professional group or network of organizations, development of strategic plan, etc.).
Tasks for the group work:
- discuss the directions and focus of the country’s legislative modernisation; define reform priorities (pursuant to the Assessment Tool);
- discuss possible difficulties and describe ways for overcoming these difficulties;
- agree on coordination mechanism among the team participants (groups of experts) and define the time frames for the activities;
- prepare presentations based on the results of the group work.

CONCLUSION: By the end of training it is necessary to analyse the training process and its results; formulate lessons learned; analyse successes and deficiencies; and prepare a training report. Based on participants’ feedback (using the training assessment questionnaire) identify their needs in the future work on reforming legislative systems. Participants may request additional materials and ask for additional trainings, seminars, round table discussion, etc. It is necessary to keep in touch with the participants on a regular basis and coordinate their future activity in reforming legislative systems and law implementation in the area of HIV prevention and care.
ANNEX A: LIST OF DOCUMENTS USED IN TRAINING


6. UN Drug Control Programme (Legal Affairs Section), *Flexibility of treaty provisions as regards harm reduction approaches* (Decision 74/10) (2002), online: http://www.aidslex.org/site_documents/Z121E.pdf.


*Documents produced by the Canadian HIV/AIDS Legal Network are available on its website at www.aidslaw.ca (search under “Publications”).*
ANNEX B: SAMPLE TRAINING PROGRAMME

**Day 1**

9.00  Registration

9.30  Opening. Practical issues and a work plan

10.00 Introduction of the participants, their expectations and areas of interest

1.45  Framework and the goal of training. Tasks and expected training results

11.00 Coffee break

11.20 Information about the project. Drug control policy and universal access to HIV-prevention and treatment: UNODC strategies

11.50 **Module 1: Model Law and international law**

   Questions

12.50 **Module 1: Assessment Tool and recommendations on its use and application**

   Questions

13.30 Lunch

14.30 **Module 2: Harm reduction**

   Questions

15.30 Coffee break

15.45 **Module 2: Human rights and harm reduction**

   Questions

16.40 **General discussion:** Obstacles for implementation of the human rights-based approaches in the process of HIV prevention and treatment among vulnerable populations

17.30 Closure of the first day's sessions

**Task:** Study the Assessment Tool and prepare questions

**Day 2**

9.00 Review of the previous day's themes

9.10 If training participants represent different countries, they give presentations about the situation in their countries (15–20 min for each country)\(^{%n}\)

11.00 Coffee break

11.20 Continuation of presentations

13.00 Lunch

\(^{%n}\) If training participants represent one country the facilitator should conduct a training session on Modules 2 and 3 followed by the session devoted to legal regulation of these issues in the national legislation.
14.00 Module 3: International conventions on drugs
   Questions

15.00 Module 3: Criminal law issues
   Questions

15.45 Coffee break

16.00 Work in groups (country groups or groups formed based on other criteria: exercise on analysis of hypothetical legislation)

16.45 Group presentations on analysis of hypothetical legislation (5 min. for each group)

17.30 Closure of the second day’s sessions

Day 3

9.00 Review of the previous day’s sessions

9.20 Module 4: Drug dependence treatment
   Questions and answers

10.30 Group work on Assessment Tool (treatment accessibility, testing for HIV and drugs, and OST, etc.) thematic groups:
    a. what documents should be included in the assessment?
    b. what groups of people should be interviewed for obtaining additional information?
    c. what issues should be taken into consideration during implementation of legislative/normative documents?

11.30 Coffee break

11.50 Presentation of the results of group work (10 min. each)

13.00 Lunch

14.00 Module 5: Syringe exchange programmes
   Questions and answers

14.40 Module 5: Medically supervised drug use facilities
   Questions and answers

15.00 Coffee break

15.20 Discussion: Apprehensions and moral considerations vs. human rights principles and evidence of effectiveness

16.00 Closure

Day 4

9.00 Review of the previous day’s sessions

1.10 Module 6: Prisons
   Questions and answers

10.30 Group work (country groups or groups formed based on other criteria): Health issues in prisons: legal
and normative aspects

Task:
a) define 2–3 of the most serious obstacles for initiation or expansion of one of the effective interventions on HIV-infection prevention in prisons;
b) offer 2–3 strategies for overcoming these obstacles.

Thematic groups: 1) Syringe distribution/exchange programmes; 2) OST and other drug dependence treatment methods; 3) STIs and condoms; 4) Voluntary counselling and testing; 5) Care and support for PLHIV; 5) Viral hepatitis and TB; 6) Prevention of violence, especially sexual violence.

11.30 Coffee break

11.50 Group reports

13.00 Lunch

14.00 Module 7: Anti-discriminatory provisions and greater participation of people living with HIV and people who use drugs in decision making

15.00 Coffee break

15.20 Meeting with organisations of people who use drugs and/or with people living with HIV or the organisations providing harm reduction services. Discussion

17.00 Closure

Day 5

9.00 Review of the previous day’s sessions

9.10 Group work (country groups)

Task:
• Discuss the countries’ main challenges and needs and define reform priorities (pursuant to the Assessment Tool);
• Discuss and describe possible difficulties and the ways for overcoming those difficulties;
• Develop a strategic plan for further activities;
• Agree on coordination mode between the team members (groups of experts) and define adequate time frames for the activities;
• Prepare a presentation

11.00 Coffee break

11.20 Continuation of group work

12.00 Group presentations

Questions

13.00 Lunch

14.00 Group presentations (continuation)

Questions and answers

15.15 Training results

15.30 Training assessment (filling in the assessment form)

15.45 Closure of the training
ANNEX C: LEGISLATIVE ANALYSIS EXERCISE

Exercise
Please familiarise yourself with the following excerpts from legislation of country X, and prepare a short analysis of its compliance with international human rights norms. Please indicate positive and negative features, and which provisions should be amended or reviewed.

1. **[X] Federal Act on narcotic drugs and psychotropic substances**

   Article 2. Schedule of narcotic drugs, psychotropic substances and their precursors controlled in [X]

   1. Narcotic drugs, psychotropic substances and their precursors controlled in [X] shall be included in the Schedule of narcotic drugs, psychotropic substances and their precursors controlled in [X] and, depending on the control measures applied by the State, shall also be included in the following lists:

   - List of narcotic drugs and psychotropic substances whose trade is prohibited in [X] pursuant to its legislation and to the international agreements to which it is party (hereinafter referred to as "List I")
     [NB. Methadone listed under List I]
   - List of narcotic drugs and psychotropic substances whose trade in [X] is restricted and in respect of which control measures are established pursuant to the legislation of [X] and to the international agreements to which it is party (hereinafter referred to as "List II")
     [NB. Buprenorphine listed under List II]
   - List of psychotropic substances whose trade in [X] is restricted and in respect of which exemptions are permitted from certain control measures pursuant to the legislation of [X] and to the international agreements to which it is party (hereinafter referred to as "List III")
   - List of precursors whose trade in [X] is restricted and in respect of which control measures are established pursuant to the legislation of [X] and to the international agreements to which it is party (hereinafter referred to as "List IV")

   ....

   Article 31. Use of narcotic drugs and psychotropic substances for medical purposes

   6. In [X] the use of narcotic drugs and psychotropic substances included in List II for the treatment of drug dependence shall be prohibited.

2. **Criminal Code X**

   Article 230. Inducement to Use Narcotic Drugs or Psychotropic Substances

   Inducement to use narcotic drugs or psychotropic substances shall be punishable by restraint of liberty for a term of up to three years, or by arrest for a term of up to six months, or by deprivation of liberty for a term of two to five years.

3. **The Model Drug Paraphernalia Act**

   Article I

   The term ‘drug paraphernalia’ means all equipment, products and materials of any kind which are used, intended for use, or designed for use, in planting, propagating, cultivating, growing, harvesting, manufacturing, compounding, converting, producing, processing, preparing, testing, analyzing, packaging, repackaging, storing, containing, concealing, injecting, ingesting, inhaling, or oth-
erwise introducing into the human body a controlled substance in violation of this Act (meaning the Controlled Substances Act of this State). It includes, but is not limited to:

(11) Hypodermic syringes, needles and other objects used, intended for use, or designed for use in parenterally injected controlled substances into the human body.

Article II

Section (A) Possession of Drug Paraphernalia
It is unlawful for any person to use, or to possess with intent to use, drug paraphernalia... Any person who violates this section is guilty of a crime and upon conviction may be imprisoned for not more than (), fined not more than (), or both.

Section (B) Manufacture or Delivery of Drug Paraphernalia
It is unlawful for any person to deliver, possess with intent to deliver, or manufacture with intent to deliver, drug paraphernalia... Any person who violates this section is guilty of a crime and upon conviction may be imprisoned for not more than (), fined not more than (), or both.

4. Controlled Drugs and Substances Act

Article 2:
(2) For the purposes of this Act,
(a) a reference to a controlled substance includes a reference to any substance that contains a controlled substance; and
(b) a reference to a controlled substance includes a reference to
(i) all synthetic and natural forms of the substance, and
(ii) any thing that contains or has on it a controlled substance and that is used or intended or designed for use
(A) in producing the substance, or
(B) in introducing the substance into a human body.

Article 4: (1) Except as authorized under the regulations, no person shall possess a controlled substance included in Schedule I, II or III.

In the Russian version of the report more legislative examples are given, i.e. related to criminal justice (prisons)
ANNEX D: EVALUATION OF TRAINING SESSION

Participant questionnaire

1. How would you assess the training quality in general?
   □ excellent   □ good   □ satisfactory   □ unsatisfactory

2. To what extent do you think the training achieved its goals?
   □ excellent   □ good   □ satisfactory   □ unsatisfactory

3. Please assess the programme of the trainings
   □ excellent   □ good   □ satisfactory   □ unsatisfactory

4. Please assess the way the training was carried out?
   □ excellent   □ good   □ satisfactory   □ unsatisfactory

5. How useful for you was the group work?
   □ excellent   □ good   □ satisfactory   □ unsatisfactory

6. Please assess the quality of materials presented before and during the training
   □ excellent   □ good   □ satisfactory   □ unsatisfactory

7. What was the most useful part of training for you?

8. What was the least useful part of training for you?

9. Did the training improve your knowledge about HIV prevention among people who inject drugs?
   □ Yes   □ No

10. Did the training improve your knowledge about HIV prevention in the correctional system?
    □ Yes   □ No

11. Did the training improve your knowledge in the area of international human rights standards?
    □ Yes   □ No

12. Did the training improve your knowledge about legislative regulation of HIV prevention measures?
    □ Yes   □ No
13. What sort of additional information would you like to receive to assist your work in upgrading legislation in the area of HIV prevention and treatment among prisoners and people who use drugs?

____________________________________________________________________________________

____________________________________________________________________________________

14. If you need technical assistance please indicate in which area:

____________________________________________________________________________________

____________________________________________________________________________________

15. Additional commentaries and suggestions:

____________________________________________________________________________________

____________________________________________________________________________________

Thank you very much for taking time and filling in this questionnaire. Your answers will help us in planning future activities. Please rest assured that this information will be used confidentially.
Checklist for country’s self-assessment of conformity of national legislation to international human rights standards

This checklist of 100 questions provides a tool for countries to rate their progress on reforming or implementing laws, policies and practices so as to strengthen HIV prevention, care, treatment and support for people who use drugs and in prisons.

Note: In the questions on this list, the term “law” is used broadly to include not only statutes but any other, subsidiary forms of legally-binding rules promulgated by government authorities, such as regulations, orders, decrees and instructions.

Please tick the box only if the answer to the question is “yes”.

National programmes and strategies

Ensuring national strategies address HIV-infection among vulnerable groups

1. Does the national programme/strategy on HIV specifically include measures for HIV prevention and treatment for people who use drugs? ☐

2. Does the national programme/strategy on HIV specifically include measures for HIV prevention and treatment for prisoners? ☐

3. Does the national programme/strategy on drugs contain provisions on harm reduction? ☐

4. Does the national programme/strategy on drugs require that people have access to voluntary treatment for drug dependence? ☐

Education and stigma reduction

5. Are there legal acts, plans or strategies ordering regular training for law enforcement bodies on the prevention of HIV-infection among vulnerable groups, including people who use drugs and prisoners? ☐

6. Are there legal acts, plans and strategies providing for including in the education of health care workers training on HIV-infection, including training on HIV prevention and other harm reduction measures among vulnerable groups such as people who use drugs and prisoners? ☐

7. Do programmes and strategies include measures to address stigmatizing attitudes and coverage by the mass media in relation to HIV-infection and people living with HIV? ☐

8. Do programmes and strategies include measures to address stigmatizing attitudes and coverage by the mass media in relation to people who use and/or are dependent on drugs? ☐

9. Do programmes and strategies include measures to address stigmatizing attitudes and coverage by the mass media in relation to prisoners? ☐

Financing of programmes and strategies

10. Does the national programme/strategy on HIV include a budget and directives for financing the measures in the programme/strategy? ☐

11. Does the national programme/strategy on drugs include a budget and directives for financing the measures in the programme/strategy? ☐
Ensuring HIV prevention and treatment in prisons

12. Is there a national plan on reforming the correctional system that includes, among other objectives, ensuring that the correctional system complies with human rights standards and good practices for health protection and promotion?

13. If there is such a plan, does it include measures for HIV prevention in prisons and pre-trial detention centres and for medical treatment for people tested HIV-positive in such settings?

14. Does this plan include measures to ensure access to voluntary treatment for drug dependence while imprisoned?

15. Does this plan on reforming the correctional system include a budget and directives on financing the measures in the plan?

Monitoring and evaluation

16. Does either national law or the national programme/strategy on HIV provide for assessment of the effectiveness of the programme/strategy in preventing HIV infection and promoting access to HIV-related care, treatment and support?

17. Does either national law or the national programme/strategy on drugs provide for assessment of the effectiveness of the drug programme/strategy?

18. Does either national law or the national plan on the correctional system provide for assessment of the effectiveness of the plan?

Involvement of persons living with HIV and vulnerable groups in the national response

19. Does the national law or the national programme/strategy on HIV include any measures for ensuring the involvement of people living with HIV in the development, implementation and evaluation of programmes on HIV/AIDS?

20. Does the national law or national programme/strategy on drugs include any measures for ensuring the involvement of people who formerly used or currently use drugs in the development, implementation and evaluation of programmes for preventing and treating drug dependence, and for preventing and treating HIV-infection among people who use drugs?

Criminal and administrative law issues

Depenalizing people who use drugs and mitigating harshness of legal penalties

21. Has the country abolished criminal liability for the mere consumption of drugs?

22. Has the country abolished administrative liability for the mere consumption of drugs?

23. Has the country abolished criminal liability for possession of small quantities of narcotic substances without intent to sell (i.e. for personal consumption)?

24. Does the law provide for directing a person with drug dependence into treatment rather than imposing a criminal sentence for offences which do not represent a grave public danger?

25. Does the law generally allow for alternatives to imprisonment in sentencing for non-violent criminal offences related to drugs (e.g. fines, treatment orders, deprivation of certain rights short of imprisonment)?
26. Has the country abolished legislative provisions defining being intoxicated during the commis-
sion of a criminal or administrative offence as an aggravating circumstance resulting in a harsher
sentence?

Avoiding legal liability for harm reduction programmes and workers

27. Does the law provide that staff and volunteers of harm reduction programmes, which distribute
educational materials and materials (e.g., sterile needles or other drug use equipment) for use
in reducing HIV transmission and other risks of harm to people who use drugs, are protected
against criminal prosecution and liability (e.g., for drug “propaganda” or “inducement to drug
consumption”, possession of illegal drugs based on drug residue on used equipment, etc.)?

28. Does the law provide that harm reduction programmes (e.g., needle and syringe programmes),
which distribute educational materials and materials for use in reducing the risks of harm (includ-
ing HIV transmission) associated with drug use, are exempt from administrative liability (e.g., for
drug “propaganda” or “inducement to drug consumption”)?

Abolishing criminal and administrative liability of groups vulnerable to HIV and human rights abuses

29. Has the country abolished criminal liability for prostitution (not involving coercion or human traf-
ficking)?

30. Has the country abolished administrative liability for prostitution (not involving coercion or hu-
man trafficking)?

31. Has the country abolished criminal liability for homosexual activity between consenting partners?

32. Has the country abolished administrative liability for homosexual activity between consenting
partners?

33. Has the country abolished criminal and administrative liability for STI exposure and non-inten-
tional STI transmission?

34. Has the country abolished criminal and administrative liability for HIV exposure and non-inten-
tional HIV transmission?

Limiting compulsory testing and treatment

35. Has the country abolished compulsory drug testing of persons in cases where the person has not
committed any illegal act but is merely “suspected” of using drugs?

36. Has the country abolished administrative liability for evading drug testing?

37. Has the country abolished administrative liability for evading treatment for drug dependence?

38. Has the country abolished administrative liability for evading testing for HIV or other STIs?

39. Has the legislation abolished administrative responsibility for evading treatment for HIV or other STIs?

Health services

40. Has the country removed HIV infection and AIDS from the list of “diseases representing a danger
to the public” / “socially significant diseases” (or other similar list)?
41. Has the country removed drug dependence from the list of “socially significant diseases” (or other similar list)?

42. Are there any national standards for treatment of drug dependence that have been adopted by a state body?

43. Has the law limited the use of compulsory treatment of drug dependence to narrow circumstances such as those in which a person poses a significant risk of serious harm\textsuperscript{1394} to himself/herself or others?

44. If the law provides for compulsory treatment of drug dependence in the case of a person convicted of an administrative offence, is treatment an alternative to imposing some other administrative penalty?

45. If the law provides for compulsory treatment of drug dependence in the case of a person convicted of a criminal offence, is treatment an alternative to imposing some other criminal sentence?

46. If the law provides for compulsory treatment of drug dependence, does the law provide an accessible means of challenging alleged infringements of rights in the course of compulsory treatment that takes place outside of correctional institutions (e.g., in “treatment-labour” camps or similar facilities)?

47. If the law provides for compulsory treatment of drug dependence, does the law provide an accessible means of challenging alleged infringements of rights in the course of compulsory treatment that takes place inside correctional institutions?

48. Does the law mandate that the state ensure the availability of a full range of services for treatment of drug dependence (e.g., detoxification, rehabilitation, etc.)?

49. Does the law specifically mandate the provision of opioid substitution treatment (OST) as one element of a comprehensive approach to treatment for drug dependence (and as an important element of HIV prevention and treatment among people who use drugs)?

50. Is methadone included in the list of substances authorized for use in medical practice, and in particular, for use in treatment of opioid dependence?

51. Is buprenorphine included in the list of substances authorized for use in medical practice, and in particular, for use in treatment of opioid dependence?

52. Is methadone included in the national list of essential medicines?

53. Is buprenorphine included in the national list of essential medicines?

54. Does the law address the need for programmes of drug dependence treatment that consider the needs of women (e.g., staying with children), including pregnant women?

55. If people with the resources can pay for drug dependence treatment that is fully anonymous, does the law also provide for free access, for those who cannot pay, to treatment that is anonymous (i.e., that does not require the person to provide his or her full name or other identifying information)\textsuperscript{1395}?

\textsuperscript{1394} See the glossary in Appendix 5 for an explanation of the term significant risk of serious harm.

\textsuperscript{1395} See the glossary in Appendix 5 for an explanation of the difference between “anonymous” and “confidential” health services.
56. Has the country abolished the registration of people who use and/or are dependent on drugs? ☐

57. If a drug user registry exists, does the law protect the confidentiality of patients, allowing the disclosure of confidential patient information only in very limited circumstances? In particular, has the law been amended to remove broad provisions that permit or require reporting of overdose cases to police or other disclosure of patient information to law enforcement authorities simply upon request by those authorities?

**HIV and STI testing and treatment**

58. Does the law require pre-test and post-test counselling, including in cases of involuntary testing? ☐

59. Does the law require that a patient give informed consent in writing to an HIV test? ☐

60. Involuntary HIV testing should be limited to (i) those donating blood, organs or other tissues or bodily samples, and (ii) in other cases, by court order only. Does the law limit involuntary HIV testing to these situations?

61. Has the country abolished involuntary/compulsory HIV testing simply on the basis that a person is suspected of being HIV-positive?

62. Has the country abolished involuntary HIV testing of people who use (or are thought to use) drugs?

63. Has the country abolished involuntary HIV testing of sex workers (or people perceived to be engaged in sex work)?

64. Has the country abolished involuntary HIV testing of prisoners?

65. Does the law mandate the availability of free testing for HIV and other STIs that is anonymous (i.e. that does not require the person to provide his or her full name or other identifying information)?

66. Does the law provide for the possibility of free anonymous treatment for STIs?

**HIV prevention among people who use drugs: harm reduction services**

67. Does the law include any provisions specifically mandating the availability of HIV prevention measures for people who use drugs?

68. Does the law explicitly mandate the implementation of needle and syringe programmes as part of HIV prevention measures for people who use drugs?

69. Does the law include any provisions directing law enforcement authorities to facilitate the work of harm reduction programmes (or at least abstain from interfering with the work of those programmes)?

70. Does the law include any provisions clearly outlining the responsibilities of outreach workers of harm reduction programmes?

71. Does the law allow (or at least not prohibit) people who use drugs to work in programmes on HIV prevention (e.g., as outreach workers)?
Patients' rights, including confidentiality

72. Does the law impose a working obligation to maintain the confidentiality of personal information (including health information such as HIV status or drug use or dependence) obtained in the course of providing health services, and impose liability for breaching confidentiality without legal authorization? 

73. Does the law explicitly outline the rights of patients in the context of receiving health services, including the right to participate in determining methods of treatment, to terminate treatment, and to mechanism for patients to seek redress for violations of rights?

Discrimination and other restrictions of rights

74. Is there a state body whose functions include protection against discrimination, including on the basis of health?

Discrimination against people living with HIV

75. Does the law forbid HIV testing for general purposes connected with employment or enrolment in an educational programme?

76. Has the country abolished rules prohibiting persons with HIV from adopting a child based on HIV status?

77. Has the country abolished discriminatory restrictions of the rights of persons living with HIV (e.g., work in health care, food sector, the military, educational institutions, etc.)?

78. Has the country abolished rules prohibiting persons with HIV from receiving a visa or entering the country?

79. Has the country abolished rules that prohibit a person with HIV from remaining in the country or that provide for the deportation of a person based on HIV-positive status?

Discrimination against people who use drugs

80. Does the law prohibit involuntary drug testing at a workplace or in educational institutions except in very limited circumstances and on a case-by-case basis?

81. In proceedings involved alleged child abuse or neglect, or situations giving rise to concerns that a child may be at risk of abuse or neglect, does the law make it clear that determinations of parental rights should be made based on individual assessments of what is in the best interests of a child, and is there a clear direction to adjudicators that such decisions should not be based on inaccurate, generalized assumptions about a person's incapacity to be a suitable parent because of his or her use of or dependence on drugs?

82. Has the country abolished rules requiring prospective students to present a certificate proving they are not on the drug user registry before enrolment in educational institutions?

83. Has the country abolished rules according to which a person's drug use per se is sufficient to bar the person from receiving a visa or entering the country?
Access to social benefits based on disability

84. Does the law contain provisions granting physical disability status to persons with HIV-infection and/or an AIDS diagnosis? □

85. Does the legislation contain provisions for granting physical disability status to persons with drug dependence? □

Prisons

86. Does the law include any provisions specifically mandating that state bodies must institute HIV prevention measures in prisons? □

87. Does the law specifically mandate that condoms be freely available in prisons? □

88. Does the law specifically mandate that disinfectants be freely available in prisons? □

89. Does the law specifically mandate that sterile needles and syringes be freely available in prisons? □

90. Does the law specifically mandate the distribution to prisoners of information on HIV and ways to protect against HIV infection? □

91. Does the law specifically mandate the distribution to prison system staff of information on HIV and ways to protect against HIV infection? □

92. Does the law specifically preserve the confidentiality of prisoners’ health information, including HIV status and drug use or dependence? □

93. Does the law mandate that the same range and quality of health services be available to prisoners as are available to people outside prisons? □

94. Does the law mandate access to antiretroviral (ARV) therapy for prisoners with HIV? □

95. Does the law mandate access to voluntary treatment for drug dependence for prisoners? □

96. Does the law mandate access to opioid substitution treatment (OST) for prisoners? □

97. Does the law mandate that prisoners have access to sterile needles and syringes as are available outside prisons? □

98. Does the law contain provisions that can be used to ensure that prisoners with compromised immune systems, including prisoners with HIV, have access to adequate nutrition? □

99. Has the country abolished discriminatory measures in relation to prisoners with HIV infection or with drug dependence, such as segregation of prisoners testing HIV-positive or prohibition on being transferred to institutions with less harsh living conditions? □

100. Does the law allow non-governmental organizations (NGOs) to do HIV prevention and support work in prisons? □
APPENDIX 5

Glossary of terms

Note: Many of the entries in this glossary are taken from the following UN terminology guides and glossaries: UN Office for Drug Control and Crime Prevention, Demand Reduction: A Glossary of Terms (2000); UNAIDS, Terminology Guidelines (2008); UNODC, Drug Abuse Treatment and Rehabilitation: A Practical Planning and Implementation Guide (2003). In some cases, some entries have been adapted slightly from the original source.

Abstinence
The term refers to the act of refraining from alcohol or other drug use, whether for health, personal, religious, moral, legal or other reasons.

Agonist
A substance that acts on receptor sites to produce certain responses. For example, both methadone and heroin are agonists for opioid receptors.

Alternatives to imprisonment
The imprisonment of people on charges relating to their personal drug use is problematic from the perspective of HIV prevention. Drugs are usually available in prisons, but often people in prison have no or limited access to opioid substitution treatment (e.g. methadone, buprenorphine) and sterile injecting equipment, which increases the risk of transmission of blood-borne diseases such as HIV infection and hepatitis. This makes prisons a high-risk environment for HIV transmission and other drug-related harms, and policies that perpetuate the incarceration of people who use drugs exacerbate the spread of HIV. Alternatives to imprisonment include such measures as administrative sanctions instead of criminal incarceration, court diversion after or before charges, and the use of non-custodial punishments if sentenced.1396

Antagonist
A substance that counteracts the effects of another agent. Pharmacologically, an antagonist interacts with a neuronal receptor to inhibit the action of agents (agonists) that produce specific physiological or behavioural effects mediated by that receptor. For example, naloxone is an antagonist that rapidly blocks opioid receptors, making it useful for quickly counteracting overdoses of opioids such as heroin.

Blood-borne virus
A virus which can be transmitted from an infected person to another person by blood-to-blood contact, such as through blood transfusion or the sharing of injecting equipment or other skin-piercing equipment (e.g., for tattooing). HIV, hepatitis B virus (HBV) and hepatitis C virus (HCV) are blood-borne viruses.

Buprenorphine
A semi-synthetic substance that has partial agonist and partial antagonist functions, which can be used in opioid substitution treatment. It has also been used extensively in many countries for the short-term treatment of moderate to severe pain. The mixed opioid-action/blocking-action appears to make buprenorphine safe as regards overdose and possibly less likely to be diverted than pure opioids. It may also provide an easier withdrawal phase, and due to a longer action, may allow for alternate-day dosing.

Court diversion
A programme of treatment, re-education or community service for individuals referred from criminal courts after being charged with drug-related criminal offences. Individuals are assigned to diversion programmes in lieu of prosecution, which is usually held in abeyance pending successful completion of the diversion programme. Pre-charge diversion refers to the systematic referral of those detected by the police to an alternative programme without prosecution (also see alternatives to imprisonment and drug treatment court).


1396
Decriminalisation and depenalization
Decriminalisation is the removal of an offence from the criminal law; the offence may still attract administrative penalties, although this need not be the case. Depenalization, a broader term, is the removal of penalties, criminal or administrative, for certain offences. The offence may remain prohibited, but no sanctions are applied.

Demand reduction
International drug control conventions use this term in relation to the aim of reducing consumer demand for controlled substances. Demand reduction strategies complement supply reduction and harm reduction approaches. Demand reduction is a broad term used for a range of policies and programmes which seek a reduction of desire and of preparedness to obtain and use illegal drugs. Demand for drugs may be reduced through prevention and education programmes to dissuade users or potential users from experimenting with illegal drugs and/or continuing to use them; drug substitution programmes (e.g. methadone); treatment programmes mainly aimed at facilitating abstinence, reduction in frequency or amount of use; court diversion programmes offering education or treatment as alternatives to imprisonment; broad social policies to mitigate factors contributing to drug use such as unemployment, homelessness and truancy. The success of demand reduction is conventionally measured by a reduction in the prevalence of drug use (i.e., by more abstinence).

Dependence syndrome
According to the WHO, “dependence, or dependence syndrome” is a need for repeated doses of the drug to feel good or to avoid feeling bad, or dependence is defined as “a cluster of cognitive, behavioural and physiologic symptoms that indicate a person has impaired control of psychoactive substance use and continues use of the substance despite adverse consequences”.

Detoxification
The process by which a person who is dependent on a psychoactive substance ceases use, in such a way that minimises the symptoms of withdrawal and risk of harm. While the term “detoxification” literally implies a removal of toxic effects from an episode of drug use, in fact it has come to be used to refer to the management of rebound symptoms of neuroadaptation, that is, withdrawal and any associated physical and mental health problems.

“Diseases that pose a risk to others” / “socially significant diseases”
Terms that exist in the legislation of some countries of the Commonwealth of Independent States (CIS), usually included in laws on public health, and give rise to certain legal consequences. Lists of such diseases are generally approved by Ministries of Health. Lists of “diseases that pose a risk to others” generally include infectious diseases such as HIV infection, tuberculosis and others. Lists of “socially significant diseases” may include HIV infection and AIDS and drug and alcohol dependence. Inclusion in the list generally means that people with these conditions receive free medication and sometimes reimbursement of travel expenses to treatment facilities. It also means that people may face certain restrictions on their rights and be subject to additional legal obligations, such as being legally compelled to undergo treatment or disclose certain information.

Drug
According to the WHO Lexicon of Alcohol and Drug Terms, a drug is a substance that is, or could be, listed in a pharmacopoeia. The term often refers specifically to psychoactive drugs, and often, even more specifically, to illicit drugs, of which there is non-medical use in addition to any medical use. See Narcotic drug

Drug policy
The aggregate of policies designed to affect the supply and demand for illicit drugs and reduction of harms from their use. Drug policy covers a range of strategies on such issues as education, treatment, drug laws, policing and border surveillance. A balanced drug policy should include demand reduction, supply reduction and harm reduction.

Drug treatment court
Imposes court-supervised treatment for people dependent on drugs who have been charged with certain
offences, such as possession of or trafficking in small quantities, usually in lieu of the normal procedure of criminal prosecution. The circumstances under which a person is eligible for participation in a drug treatment court will vary depending on how a drug treatment court system is set up and defined in the law. Whether a person charged with an offence is eligible for diversion into a drug treatment court scheme before entering a plea to the offence with which he or she is charged, or must first plead guilty to the offence, will vary across jurisdictions. Normally, an accused person participates in a structured outpatient programme with case management, including by the court through regular supervision. Normally, if the person “succeeds” in the treatment programme, in the court’s assessment, then the standard criminal penalty is not applied; if the person is deemed to “fail” with the requirements of the treatment programme imposed by the court, she or he may be prosecuted and punished through the normal criminal justice procedure. Drug treatment courts exist in Australia, Canada, the United States, the United Kingdom and some other countries. Though the drug treatment courts attempt to reduce harm to the accused of non-violent drug-related offences by diverting them from the penal system and assisting in rehabilitation, the fact that participants enter treatment under the threat of incarceration, or abstain from drugs to avoid sanctions, has serious implications for the human and legal rights of the offender. These include possible violations of the right to due process and the principle of presumption of innocence, considerations that should be addressed in the design of any such initiatives. Concerns have also been raised about whether the evaluations of drug treatment courts show them to be particularly effective, and whether resources are better spent on expanding access to voluntary drug dependence treatment services that are evidence-based, services for which the need often greatly exceeds the availability.

Gender and sex
The term “sex” refers to biologically determined differences, whereas the term ‘gender” refers to differences in social roles and relations between men and women. Gender roles are learned through socialisation and vary widely within and between cultures. Gender roles are also affected by age, class, race, ethnicity and religion, as well as by geographical, economic and political environments.

Global Fund to Fight AIDS, Tuberculosis and Malaria
The Global Fund to Fight AIDS, Tuberculosis and Malaria, established in 2001, is an independent public-private partnership. Its purpose is to attract, manage and disburse additional resources to make a sustainable and significant contribution to mitigate the impact caused by HIV infection, tuberculosis and malaria in countries in need, while contributing to poverty reduction as part of the Millennium Development Goals.

Greater involvement of people living with HIV/AIDS (GIPA) and people who use drugs
GIPA, an acronym for the “greater involvement of people living with HIV/AIDS,” appeared first in the 1994 final Declaration of the Paris AIDS Summit. Greater meaningful involvement of people living with HIV, people who use drugs, and people who are most at risk of HIV (and hepatitis C virus) in the national and international response to HIV and hepatitis C is essential for respecting and protecting human rights, and for the protection of individual and public health. Greater and meaningful involvement of affected communities in drafting, implementation, monitoring and evaluation of national HIV strategies, legislation and programmes — and of related laws, strategies and programmes, such as those dealing with drugs and drug use — is required as a matter of human rights such as the right to participate in decision making affecting one’s life, and positively affects quality and efficacy of services.

Harm reduction
In the context of alcohol or other drugs, harm reduction refers to policies or programmes that focus directly on reducing the harm resulting from the use of alcohol or other drugs, both to the individual and the larger community. The term is used in particular for policies or programmes that aim to reduce the harm from drug use without necessarily requiring abstinence. Some harm reduction strategies designed to achieve safer drug use may, however, precede and support subsequent efforts to achieve total absti-
ence. Examples of harm reduction include needle/syringe exchanges to reduce rates of needle-sharing among injecting drug users, opioid substitution treatment and safer drug consumption facilities. The term ‘harm reduction’ began to be used more widely in connection with attempts to stop the spread of HIV among injecting drug users in the early 1980s. The extent to which continued drug use is discouraged during the implementation of a harm reduction strategy varies greatly according to the guiding philosophy of the service provider. Harm reduction typically involves establishing a hierarchy of risky behaviours and involves individuals or communities working to find a position on the hierarchy which is acceptable to them while reducing harms or risk of harms. Broad definitions of harm reduction allow that abstinence-oriented programmes may be considered harm-reducing if they can be shown to reduce drug-related harm rather than just reduce use and if they are not coercive or punitive in their approach. Harm reduction as such is neutral regarding the wisdom or morality of continued drug use and should not be seen as synonymous with moves to legalize, decriminalize or promote drug use.

**Highly active antiretroviral therapy (HAART)**
Treatment aimed at aggressively suppressing viral replication in persons living with HIV and thereby slow the progress of HIV disease, as well as reducing infectiousness by dramatically reducing the person’s viral load (i.e., level of virus in the person’s blood or other bodily fluids). The usual HAART regimen combines three or more different antiretroviral medications (ARVs).

**HIV-related disease**
Symptoms of HIV-infection may occur both at the beginning of HIV infection and after a person’s immune system is compromised by HIV, leading to AIDS. During the initial infection with HIV, when the virus comes into contact with the mucosal surface, it finds susceptible target cells and moves to lymphoid tissue where massive production of the virus ensues. This leads to a burst of high-level viraemia (virus in the blood stream) with wide dissemination of the virus. Some people may have flu-like symptoms at this stage but these are generally referred to as symptoms of primary infection rather that HIV-related disease. The resulting immune response to suppress the virus is only partially successful and some virus escapes and may remain undetectable for month to years. Eventually high viral turnover leads to destruction of the immune system, sometimes referred to as advanced HIV infection. HIV disease is, therefore, characterised by a gradual deterioration of immune function. During the course of infection, crucial immune cells, called CD4+ T cells, are disabled and killed, and their numbers progressively decline.

**Human immunodeficiency virus (HIV)**
The virus that weakens the immune system, ultimately leading to AIDS. There are HIV-1 and HIV-2 types of viruses, which are similar in their viral structure, modes of transmission, and resulting opportunistic infections, but have different geographical patterns of infection, and propensity to progress to illness and death. Compared to HIV-1, HIV-2 is found primarily in West Africa and has a slower, less severe clinical course. HIV is transmitted through body fluids, including blood (i.e. through blood transfusion, shared drug-injection equipment, shared implements for tattooing, or improperly sterilized medical equipment), via sexual activity that involves exposure to significant enough quantities of body fluids (e.g., genital secretions), and from mother to child in utero, during childbirth or by breast-feeding.

**Human rights-based approach**
An approach to making and implementing law and policy (at various levels) that is normatively based on international human rights standards and is directed to protecting and promoting human rights. In the context of HIV infection, a human rights-based approach is one that recognizes that human rights principles must guide HIV prevention and treatment efforts, including by informing relevant areas of law and policy, such as those dealing with drugs or regulating prisons and other places of detention. A human rights-based approach recognizes that access to goods, services and information for HIV prevention, care, treatment and support is a matter of human rights, and that the denial or violation of human rights increases the vulnerability of individuals and communities to HIV and undermines effective responses to the epidemic. Such an approach recognizes that respecting, protecting and fulfilling human rights, and in particular the rights of those who are most marginalized and vulnerable to infringements of human rights, is a key necessary element of effective policies and programmes. A human rights-based approach is relevant to international and national governmental organisations and structures, and to civil society organizations, engaged in responding to the HIV epidemic.
Incidence
HIV incidence (sometimes referred to as cumulative incidence) is the number of new cases arising in a given period in a specified population. UNAIDS normally refers to the number of people (of all ages) or children (0–14 years) who have become infected during the past year. In contrast, HIV prevalence refers to the number of infections at a particular point in time (like a camera snapshot). In specific observational studies and prevention trials, the term incidence rate is used to describe incidence per a hundred thousand persons per years of observation.

Injecting equipment
The paraphernalia used for drug injection. This can include such items as a needle and syringe, a spoon for mixing, water or acid for dissolving powdered drugs, filter material to draw the solution through when filling the syringe (e.g. piece of cigarette filter, cotton wool, paper), an alcohol swab to clean the injection site, and a tourniquet.

Key populations at higher risk of HIV exposure
UNAIDS recommends not to use the term “high-risk group” because it implies that the risk is contained within the group whereas, in fact, all social groups are interrelated. It may also lull people who don’t identify with such groups into a false sense of security, and increase stigmatization and discrimination. Instead it recommends referring directly to “higher risk of HIV exposure”, “sex without a condom”, “unprotected sex”, or “using non-sterile injection equipment” rather than to generalize by saying “high risk group.”

Low-threshold and high-threshold services
Services adopting a low-threshold approach aim to reach more people in need of services (i.e. people who use drugs) earlier and to remain in contact with them in order to prevent health damage while not imposing many requirements that may pose barriers to their use of such services (e.g., abstinence from all drug use, compliance with strict rules that will make a service less user-friendly). Low-threshold services represent a unique opportunity for the provision of specific health services, such as education about how to minimize risks of harm associated with drug use, vaccination campaigns, and increasingly also the treatment of infectious diseases. High-threshold services impose more requirements on clients.

Methadone
A synthetic opioid drug used in maintenance therapy for those dependent on opioids, such as heroin. It has a long half-life, and can be given orally once daily with supervision. It is the most widely used treatment for opioid dependence in many countries. When given in an adequate dose to opioid-dependent individuals, methadone tends to reduce desire to use heroin and other opioids, eliminates opioid withdrawal, and can block the euphoric effects of other opioid drugs. Methadone is also used as a medication for pain management.

Men who have sex with men (MSM)
This term is useful as it includes not only men who self identify as gay or homosexual and have sex only with other men but also encompasses bisexual men, and men who identify themselves as heterosexual but who may nonetheless at times have sex with other men.

MTCT
Acronym for “mother-to-child transmission” of HIV. PMTCT is the acronym used to denote programmes aimed at the “prevention of mother-to-child transmission.”

Naloxone
Naloxone is a narcotic antagonist which reverses the respiratory, sedative and hypotensive effects of heroin overdose. It can be injected intramuscularly, intravenously or subcutaneously. A nasal spray preparation is now also available in some countries. It is an opioid receptor blocker that antagonises the actions of opioids. It reverses the features of opiate intoxication and is prescribed for the treatment of overdose with that group of drugs.

Naltrexone
A drug that antagonises the effects of opioids. Its effects are similar to those of naloxone, but it is more
potent and has longer duration of action (making naloxone more suitable for emergency use to rapidly reverse opioid overdose). It is used in various ways in the treatment of opioid dependence and also alcohol dependence. The most widely adopted dependence use is to prescribe at a dose that will block the psychoactive effects of all opioids; the objective of such dosing is to minimise the chance of relapse to opioid use.

**Narcotic drug**
One kind of controlled psychoactive substance (see *Psychoactive substance*), of natural or synthetic origin, whose production and distribution are regulated by relevant UN Conventions and national legislation. In this report and in legal usage it is often used to mean illicit drugs and psychotropic substances, irrespective of their pharmacology.

**Needle and syringe programme (NSP), needle exchange programme (NEP)**
Interventions aimed at reducing the repeated use and sharing of needles, in order to reduce the transmission of blood-borne viruses (such as HIV and hepatitis) and other harms. Such programmes were first developed in response to the advent of HIV infection and quickly spread to many countries in which injecting drug use was experienced as a problem. Strictly speaking, a needle “exchange” programme provides clean injecting equipment in exchange for returned used needles which can then be disposed of safely. In practice, research has shown that restricting such programmes to pure “exchanges”, and particularly a rule of one-to-one exchange that provides only one clean needle for every used needle returned, undermines the full public health benefit of such programmes by unnecessarily limiting access to sterile injecting equipment. As a result, many NSPs do not require a strict “exchange”, but rather distribute clean needles on demand without such strict limitations, in the interests of maximizing users’ access to sterile injection equipment. Many programmes will provide not only syringes but also related items needed to minimize the risks of blood-borne diseases and other injuries associated with drug use (e.g. cookers, alcohol swabs and other items), as well as also providing condoms and information about HIV and available services. Syringe dispensing machines and pharmacy-based distribution (and easy and cheap syringes available for purchase at the pharmacy) are other means of ensuring access to sterile injecting equipment.

**Opiate**
According to the *WHO Lexicon of Alcohol and Drug Terms*, “opiate” is one of a group of alkaloids derived from the opium poppy with the ability to induce analgesia, euphoria, and in higher doses, stupor, coma and respiratory depression. The term opiate excludes synthetic opioids (e.g. methadone).

**Opioid**
According to the *WHO Lexicon of Alcohol and Drug Terms*, opioid is the generic term applied to alkaloids from the opium poppy, their synthetic analogues, and compounds synthesized in the body, which interact with the same specific receptors in the brain, have the capacity to relieve pain, and produce a sense of well-being (euphoria). The opioid alkaloids and their synthetic analogues also cause stupor, coma and respiratory depression in high doses. Over time, opioids induce tolerance and neuroadaptive changes that are responsible for rebound hyperexcitability when the drug is withdrawn.

**Opioid substitution therapy (or treatment) (OST)**
A method of pharmacological treatment for those with opioid dependence, proven to be effective and widely used in many countries for decades. In addition to its own therapeutic value as a method of treating those with addictions to illicit opioids (e.g., heroin), OST is recommended by UN and international and national health authorities as an effective and important intervention to prevent transmission of HIV and other blood-borne infections among people who inject drugs. OST is defined as the administration of thoroughly evaluated opioid agonist, by accredited professionals, in the framework of recognized medical practice, to people with opioid dependence, for achieving defined treatment aims. In other words, the person with opioid dependence is administered a certain medicine (opioid agonist) obtained legally under prescription from qualified medical personnel and consumed in less risky ways (e.g., as an oral solution in the case of methadone or sublingual tablets of buprenorphine), in place of illegally-obtained opioids that are often consumed in ways that risk disease transmission (e.g. injecting with non-sterile equipment). Agonist pharmacotherapy programmes may be of two general types: in detoxification

---

1399 Guidelines for the Psychosocially Assisted Pharmacological Treatment of Opioid Dependence, WHO, 2009
programmes, doses of the agonist will be reduced over a period of time until a drug-free state has been reached, while maintenance programmes prescribe higher doses of the substitute agonist for longer periods of time.\textsuperscript{1400}

**Opportunistic infections**
Illnesses caused by various organisms, some of which usually do not cause disease in persons with healthy immune systems. Persons living with advanced HIV infection may have opportunistic infections of the lungs, brain, eyes and other organs. Opportunistic illnesses common in persons diagnosed with AIDS include pneumonia, cryptosporidiosis, bacterial infections, other parasitic, viral and fungal infections; and some types of cancers. Tuberculosis is the leading HIV-associated opportunistic infection in developing countries.

**Outreach**
A community-based activity with the overall aim of facilitating improvement in health and reduction of drug-related risk or harm for individuals and groups not effectively reached by existing services or through traditional health education channels. Peer outreach projects use current and former members of the target groups (such as injecting drug users) as volunteers and paid staff.

**Overdose**
According to the *WHO Lexicon of Alcohol and Drug Terms*, “overdose” is the use of any drug in such an amount that acute adverse physical or mental effects are produced. Overdose may produce transient or lasting effects, or death; the lethal dose of a particular drug varies with the individual and with circumstances (including the concentration of the drug consumed).

**Peer intervention**
A treatment or service that is delivered by a trained individual who is close in gender or age group or other socio-economic category to the target group (e.g. personal experience of drug use).

**People living with HIV**
UNAIDS recommends avoiding expressions “people living with HIV and AIDS” and the abbreviation PL-WHA, and to use instead “people living with HIV” and PLHIV. This reflects the fact that an infected person may continue to live well and productively for many years. A term such as “people living with HIV” is also much preferable to terms such as “AIDS patients” or “AIDS carriers” or “AIDS victims,” because it defines people by their disease first and foremost, rather than emphasizing that they are people first and foremost, and entitled to respect and protection of their rights as persons, something particularly important in the face of widespread HIV-related stigma and discrimination, including sometimes in the law. Groups of PLWH have rejected labels such as “AIDS victims” because “it implies helplessness, and dependence upon the care of others.”\textsuperscript{1401} With the term “person living with HIV/AIDS,” a “new social and/or political identity was born, stressing that people who are HIV positive or have AIDS are not dying; they are living and they are able to take care of their own lives.” It should also be noted that referring to some people living with HIV as “innocent victims” wrongly implies that people infected in other ways are somehow deserving of punishment, further contributing to the stigmatization and discrimination surrounding HIV and affecting particular vulnerable groups.

**People who use drugs and people who are dependent on drugs (or with drug dependence)**
For some people, these terms are preferable to terms such as “drug addicts” or “drug (ab)users,” which are seen as derogatory and which often result in alienation rather than creating the trust and respect required when dealing with those who use drugs. Similarly to using a term such as “people living with HIV”, terminology such as “people who use drugs” avoids reducing people to the fact that they use or inject drugs, and instead identifies them as people first and foremost, clarifying that drug use or injection drug use is just one aspect of their lives. Given the widespread dehumanization of people who use drugs, and in

---


particular people with drug dependence, insisting on the humanity and dignity of people who use drugs is an important reminder, including to those who makes laws and policies that affect very profoundly the lives of people who use drugs.

**Prevalence**
Usually given as a percentage, HIV prevalence quantifies the proportion of individuals in a population who have HIV at a specific point in time. UNAIDS normally reports HIV prevalence among adults, aged 15–49 years. We do not write “prevalence rates” because a time period of observation is not involved. HIV prevalence can also refer to the number of people living with HIV as in “by December 2007, an estimated 33.2 million people were living with HIV worldwide.”

**Prevention**
An intervention designed to avoid or substantially reduce risk for the acquisition or further development of adverse health and interpersonal problems. Programmes at preventing harmful drug use vary widely in content and philosophy. The most effective programmes are multidimensional and contain a mixture of straight-talking education sessions about drugs and drug use; skills to deal with stress and personal and relationship problems; and drug resistance skills. The specific content of a programme can be specifically adapted to the nature and needs of the target population. HIV prevention includes harm reduction measures such as needle and syringe programmes (NSPs), opioid substitution therapy (OST), supervised drug consumption sites, condom distribution, as well as distribution of information about HIV and easy access to health services.

**Prisons**
For purposes of simplicity, this report uses the term “prisons” broadly to denote all institutions of the correctional system, including places of pre-trial and post-conviction detention. The term “prisoner” is used broadly to include adults detained at correctional facilities during criminal investigations, prior to or after sentencing.

**Psychoactive substance**
According to the *WHO Lexicon of Alcohol and Drug Terms*, a “psychoactive substance” is one that, when ingested, alters mental process, that is, thinking or emotion. This term is the most neutral and descriptive term for the whole class of substances, licit and illicit.

**Registry of people who use drugs and people dependent on drugs**
In many countries of the Commonwealth of Independent States (CIS), drug dependence treatment services keep registries of people who are characterized as using drugs (and those who are dependent on drugs). Commonly, the practice is to maintain a “preventive” registry, which holds data on people who use drugs, and keeps it usually for a set term such as one year, while another registry holds data on people diagnosed as being drug-dependent and keeps that data for a longer period, usually not less than 3-5 years. Being on the registry generally carries a range of legal consequences, including limitations of certain rights. Often employers and educational institutions request that a prospective employee or student provide a certificate confirming that he or she is not listed in the drug registry. There are also reports of frequent violations of confidentiality of information on these registries, and in many instances, the law expressly provides for easy access to such information by law enforcement authorities or for various law enforcement purposes, which raises human rights concerns discussed in this report.

**Rehabilitation**
According to the *WHO Lexicon of Alcohol and Drug Terms*, in the field of substance use, “rehabilitation” is the process by which an individual with a drug-related problem achieves an optimal state of health, psychological functioning and social well-being. Rehabilitation typically follows an initial phase of treatment in which detoxification and, if required, other medical and psychiatric treatment occurs. It encompasses a variety of approaches including group therapy, specific behavioural therapies to prevent relapse, involvement with a mutual-help group, residence in a therapeutic community, vocational training and work experience. There is an expectation of social integration into a wider community.

**Relapse**
According to the *WHO Lexicon of Alcohol and Drug Terms*, relapse is a return to drinking or other drug use after a period of abstinence, often accompanied by reinstatement of dependence symptoms. Some distinguish between relapse and lapse (‘slip’), with the latter denoting an isolated occasion of alcohol or drug use. The rapidity with which signs of dependence return is thought to be a key indicator of the degree of drug dependence.

**Relapse prevention**
According to the *WHO Lexicon of Alcohol and Drug Terms*, relapse prevention is a set of therapeutic procedures employed in cases of alcohol or other drug problems to help individuals avoid or cope with lapses or relapses to uncontrolled substance use. The procedures may be used with treatment based on either moderation or abstinence, and in conjunction with other therapeutic approaches. Patients are taught coping strategies that can be used to avoid situations considered dangerous precipitants of relapse, and shown, through mental rehearsal and other techniques, how to minimize substance use once a relapse has occurred.

**Remission**
A disease is said to be in remission if symptoms cease for a while, even if the underlying condition has not been cured. In relation to drug dependence, people who are dependent on drugs are said to be in remission if they have achieved a period of abstinence.

**Right to health**
The “right to health” is recognised in various international documents, including the 1948 *Universal Declaration of Human Rights*. The 1966 *International Covenant on Economic, Social and Cultural Rights*, one of the primary human rights treaties of the UN system that has been ratified by a large majority of the world’s states, recognizes the “right to the enjoyment of the highest attainable standard of physical and mental health.” Every state has ratified at least one international human rights treaty recognising the right to health in some form, such as the *Constitution of the World Health Organization* (adopted in 1946 and entered into force in 1948) or various regional human rights treaties. The right to health includes “underlying determinants of health”, such as safe drinking water and food, adequate nutrition and housing, access to essential medicines, healthy working and environmental conditions, health-related education and information, and gender equality. Access to medication for the treatment of HIV infection and tuberculosis has specifically been recognized repeatedly by UN members states as a fundamental element of the right to health. The right to health requires non-discriminatory access to health goods, services and information. The right to health includes the right to be free from non-consensual medical treatment, and to be free from torture and other cruel, inhuman or degrading treatment or punishment.

**Risk of harm to self or others**
A basis on which a person may justifiably be subjected to involuntary treatment (e.g. for drug dependence). Whether a person poses an imminent and significant risk of causing harm to himself or herself, or to others, should be determined on an individual basis by an appropriate independent legal authority, with the benefit of expert, evidence-based clinical assessment as to the risk of harm, the severity of the harm and whether imposing treatment that is available holds a reasonable prospect of assisting the person to address his or her drug dependence so as to avoid that harm.

**Supervised (or safer) injection sites / supervised drug consumption facilities**
A health facility that is legally approved and that allows the consumption of drugs with sterile equipment under the supervision of health professionals and with access to medical care if needed, including the potential for intervening in the event of an overdose. It is a specialised health intervention, a part of a wider network of services for people who use drugs. Among other objectives, such facilities aim to reduce the risk of transmission of blood-borne infections, in particular HIV and hepatitis, and to reduce the likelihood of illness and death resulting from overdose. Ideally, such facilities will also provide basic health care for simple medical problems commonly experienced by people who use drugs (e.g. abscesses in injecting spots) and provide a means of connecting people to other health or social services (e.g. treatment for drug dependence, assistance with getting food or shelter).

---

1402 For more detail about the right to health in international law, see Office of the UN High Commissioner for Human Rights and the WHO, *The Right to Health: Fact Sheet No. 31* (June 2008), online: http://www.ohchr.org/Documents/Publications/Factsheet31.pdf.
Sexually transmitted infection (STI)
Also called venereal disease (VD), infections spread by the transfer of organisms from person to person during sexual contact. In addition to ‘traditional’ STI (e.g., syphilis, chlamydia, gonorrhoea), the spectrum of STIs includes HIV, which causes AIDS, human papilloma virus (HPV) which can cause cervical or anal cancer, genital herpes, hepatitis B and other infections. The complexity and scope of sexually transmitted infections have increased dramatically since the 1980s; more than 20 disease-causing organisms and syndromes are now recognized as belonging in this category.

Sex work/Prostitution
According to UNAIDS recommendations, the term “prostitution” should be used only in respect of juvenile prostitution. For adults, the term “sex work” should be used. The term “sex worker” is intended to be non-judgemental, focusing on the conditions under which sexual services are sold.

Stigma and discrimination
As the traditional meaning of stigma is a mark or sign of disgrace or discredit, the correct term would be stigmatization and discrimination. HIV-related stigmatization and discrimination is a “process of devaluation” of people either living with or associated with HIV infection. The stigma often stems from the underlying stigmatisation of sex and injecting drug use. Discrimination follows stigma and is the unfair and unjust treatment of an individual based on his or her real or perceived HIV status. Stigma and discrimination breach fundamental human rights and can occur at a number of different levels including political, economic, social, psychological and institutional. Stigma and the potential for discrimination are strong incentives for people to avoid being tested for HIV. This can lead to the risk of faster disease progression for the individual living with HIV and also contributes to the risk of spreading HIV to others. HIV-related stigma builds upon, and reinforces, existing prejudices. It also plays into, and strengthens, existing social inequalities – especially those of gender, sexuality and race (e.g., stigmatization and discrimination against men who have sex with men or sex workers).

Substitution treatment (substitution therapy, drug substitution, medication assisted therapy)
Treatment of drug dependence by prescription of a substitute drug for which cross-dependence and cross-tolerance exist. The term is sometimes used in reference to a less hazardous form of the same drug used in the treatment. The goals of drug substitution are to eliminate or reduce use of a particular substance, especially if it is illegal, or to reduce harm from a particular method of drug use (e.g., sharing of needles) such as the attendant dangers to health and the social consequences. Drug substitution is often accompanied by psychological and other treatment. Opioid substitution therapy (OST) is the most common form of drug substitution and is conducted using such evidence-based and approved medications as methadone and buprenorphine.

Supply reduction
A broad term used for a range of activities designed to stop the production and distribution of illicit drugs. Efforts at reducing production often include crop eradication or through large programmes of developing alternative income-generating activities for those growing crops used to produce illicit drugs, as well as the suppression of illicit laboratories and the control of precursor chemicals, while policing efforts aim to disrupt the local or cross-border distribution and sale of substances. In some cases, supply reduction efforts have involved large-scale military operations. Supply control is a term often used to cover police and customs activities.

Testing
HIV testing is pivotal to both HIV prevention and treatment interventions. It is widely recognised that all HIV testing should reflect the “three Cs” — that is, testing should be confidential; accompanied by counselling; only be conducted with informed consent which is voluntarily given. VCT is an abbreviation for the process of “voluntary counselling and testing,” and is also known as “client-initiated testing,” in opposition to what has been labelled as “provider-initiated testing”. Provider-initiated testing refers to the process of a health care provider performing HIV testing under certain defined circumstances when an individual is seeking medical care, such as when a patient presents with symptoms that may be attributable to HIV infection or has an illness associated with HIV such as tuberculosis, or as part of the clinical

This definition is based on the UNAIDS fact sheet “Stigma and Discrimination” (December 2003).
evaluation of certain patients, such as those who present with an STI or women who are pregnant. Under the **opt-in approach**, testing is done only once the patient has formally given consent for HIV testing. Under the **opt-out approach**, testing is done routinely unless the patient declines to be tested. There are ongoing debates about whether “opt-out” approaches to HIV testing are advisable or justified, but there is consensus that all HIV testing should always be carried out under conditions respecting three Cs – confidentiality, counselling and informed consent.

**Anonymous vs. confidential testing and treatment:** Testing/treatment is considered to be truly *anonymous* when no identifying information (such as name, address and other information) of the person is taken, known or requested by a service provider. Testing/treatment is considered to be *confidential* when information about the person is kept secret and known only to certain parties, such as the health care provider working with a patient. As a matter of ethics, human rights and good health practice, testing and treatment should always be at least confidential, meaning that a patient’s information cannot be shared without his or her consent, and only very limited exceptions may be allowed by law with proper and careful justification. Experience with HIV infection and STIs, and the stigmatization and discrimination related to them, has also shown the value of ensuring access to truly anonymous testing for such infections so as to increase the number of people willing to seek testing, particularly those who may be most marginalized and also at greater risk of infection.

**Mandatory vs. compulsory vs. voluntary testing:** According to UNAIDS, HIV testing (and treatment) should be voluntary. But sometimes laws and policies, or even the practices of some actors (both public and private), derogate from these principles and impose *mandatory* or *compulsory* testing or treatment. HIV testing can be said to be *mandatory* when it is made a necessary prerequisite for a person to obtain a specific status, benefit, service or access to a given situation, or is a necessary consequence of this, but the individual still has the “choice” of avoiding testing by forgoing such a status, benefit, service or access. (The degree to which this is truly a free “choice” will obviously vary in the circumstances and for the individual.) For example, imposing a requirement of HIV testing as a condition of donating blood, immigrating to a country or employment, is to impose mandatory testing. The person can avoid being tested for HIV by forgoing employment, immigration, or being a blood donor. HIV testing (or other testing, such as for drug use) can be said to be *compulsory* when it is required by a law or policy and the person cannot choose to refuse testing and cannot avoid it except upon pain of legal penalty — for example, if a court or a law enforcement body orders a person to be tested for HIV (or for drug use) and force can be used to compel that person to undergo testing if he or she objects. According to UNAIDS, mandatory HIV testing is permitted only in case of blood and bodily tissues or other substances donated for purposes of possible transplantation; other instances of mandatory HIV testing (e.g. as a condition of employment or access to services) are not justified. Compulsory testing will rarely, if ever, be justifiable. However, some countries employ involuntary testing and treatment in wider circumstances (e.g. compulsory HIV and drug testing of prisoners, compulsory drug dependence treatment of prisoners), which unjustifiably violate human rights.

**Drug dependence treatment**
According to WHO, the term “treatment” refers to “the process that begins when psychoactive substance abusers come into contact with a health provider or any other community service and may continue through a succession of specific interventions until the highest attainable level of health and well-being is reached.” More specifically, treatment may be defined “as a comprehensive approach to the identification, assistance, health care, and social reintegration with regard to persons presenting problems caused by the use of any psychoactive substance.... The definition of treatment uses the broad concept of rehabilitation adopted by United Nations agencies such as the International Labour Organisation (ILO), the United Nations Educational, Scientific and Cultural Organization (UNESCO) and WHO. It includes the equalization of opportunities and community involvement. The definition is also compatible with the WHO's constitutional objective, which is ‘the attainment by all peoples of the highest possible level of health.’ The aim of treatment, within this broader context, is to improve the health and quality of life of persons with problems caused by their use of psychoactive substances.”

include detoxification, the use of substitution therapy (including for maintenance on such therapy over a longer-term) and/or psychosocial therapies and counselling. Treatment aims at reducing the dependence on psychoactive substances, as well as reducing the negative health and social consequences caused by or associated with the use of such substances.

**Compulsory or coerced treatment**

As noted above, a general underlying principle of health care interventions is that such interventions should be only undertaken with informed consent, meaning with the voluntary agreement of the patient. In some cases, drug dependence treatment (and treatment of other conditions) may be at odds with this principle of voluntariness. Treatment may be *compulsory* in the sense of being effectively imposed by force by some authority, with no possibility of avoiding the intervention, such as drug dependence treatment imposed upon some people in prison according to the law in some countries. Treatment may also be *coerced* under the law; for example, a court may order that an individual undergo some form of drug dependence treatment as an alternative to a custodial sentence. Treatment is coerced in the sense that failure to enter the programme or comply with its rules and regulations may result in the individual receiving the standard criminal justice penalty. Involuntary treatment raises human rights concerns; compulsory treatment will possibly be justifiable only in very exceptional circumstances and even systems for coercing to treatment (e.g., drug treatment courts) require careful scrutiny in light of the need to respect such rights as liberty, privacy and security of the person.

**Withdrawal syndrome**

A group of symptoms of variable severity which occur on cessation or reduction of drug use after a prolonged period of use and/or in high doses. The syndrome may be accompanied by signs of both psychological and physiological disturbance. A withdrawal syndrome is one of the indicators of a dependence syndrome.

**Vilification**

Vilification is any public act that could incite others to hate, have serious contempt for, or severely ridicule an individual because they belong to a particular group or have a particular characteristic (e.g., people with HIV, or people who use or are dependent on drugs).