HIV and Drug Use: Compulsory Detention and Drug ‘Treatment’

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Compulsory centres are facilities where active or suspected drug users are forced to go for “treatment” for drug dependence and rehabilitation.
Some of the most egregious violations of the right to health have occurred in the context of “treatment” for drug dependence.

Anand Grover, Report of the Special Rapporteur on the right to health, UN Gen Assembly August 2010
Compulsory Detention and Drug ‘Treatment’ is a major problem because...

1. Mandatory, boot camp ‘rehabilitation’ through labor
2. Not evidence based
3. Limited or no HIV programs
4. Human rights violations
5. No distinction between occasional users and those who are drug dependent
6. Incubator for HIV transmission
7. Drug treatment law and policy often poorly defined and in conflict with HIV/Harm reduction

Compulsory drug detention is a major impediment to building an enabling environment for HIV prevention with people who use drugs
<table>
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<tr>
<th></th>
<th>Cambodia</th>
<th>China</th>
<th>Viet Nam</th>
</tr>
</thead>
<tbody>
<tr>
<td>Managed by</td>
<td>Police, Ministry of Social Affairs, local government</td>
<td>Public Security Bureau</td>
<td>Department of Social Evils Prevention/ Youth Union/some private</td>
</tr>
<tr>
<td>Cost</td>
<td>$100-200 for entry $50/mo (inmates/relatives)</td>
<td>$292–438 (inmates/relatives)</td>
<td>$100M in 2006 (program)</td>
</tr>
<tr>
<td>Est. Detention Population</td>
<td>1500–1700 (2007)</td>
<td>140,000–500,000</td>
<td>80,000+</td>
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<tr>
<td>HIV Prevalence</td>
<td>N/A</td>
<td>5%</td>
<td>16–58% (2009)</td>
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<tr>
<td>HIV Treatment and Prevention</td>
<td>No condoms No ART (except via informal arrangements</td>
<td>HIV testing upon arrival ART in some centers, planned for others</td>
<td>No condoms, some HIV education ART via informal arrangement</td>
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## Drug Treatment

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<tbody>
<tr>
<td><strong>Drug Treatment</strong></td>
<td>Isolation, no pharmacotherapy</td>
<td>Abstinence-based, re-education through labor</td>
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<tr>
<td><strong>Period of Detention</strong></td>
<td>3-6 months</td>
<td>2 years + 1-2 years post detox management</td>
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<tr>
<td><strong>Relapse Rates</strong></td>
<td>close to 100%</td>
<td>90-100%</td>
</tr>
<tr>
<td><strong>Exit care/ Follow-Up</strong></td>
<td>Minimal to nonexistent</td>
<td>Transitional program supported by PEPFAR</td>
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Sources: UNODC; WHO; UNAIDS, HAARP; HRW; HPI/GMR-C; OSI
Comparison of HIV among IDU: (06) Center and Non Center (HCMC City 2009)

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<th>HIV prevalence among released IDUs</th>
<th>HIV prevalence in non-center IDUs</th>
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<tr>
<td>58.2%</td>
<td>39.7%</td>
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Official figures - 10.5% death rate among all detainees (many more possibly released in a terminal condition).
(DoLISA HCMC, 2008)
Center numbers increasing

Sources UNODC 2010; other personal communication
Key Issues

- Major barrier to enabling environment and scaled up services
- Impedes public health and harm reduction approaches
- Source of human rights violations
- Centers become incubators for HIV
- HIV treatment-interrupted costs, second/third line costs to the health system
- Compounds other health issues- mental health- HCV
- Severely limits the role of people who inject drugs in the policy and program response
Scale up in Asia Requires Policy Engagement, pilot testing, and replication of good models

- System is established and change requires dialogue with drug control, police, community, **PWID** and health care workers
- Need research/documentation of impact of compulsory settings (e.g., data on HIV prevalence)
- Pilot open, voluntary centers
- Scale up community based drug treatment-promising models emerging in Malaysia/Cambodia
- Strengthen and align legal and policy frameworks
- RTI Asia supporting the development of transitional roadmap from compulsory to voluntary
Contact

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