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Implementation of the Political Declaration and Plan of Action on International Cooperation towards an Integrated and Balanced Strategy to Counter the World Drug Problem: Demand reduction and related measures

Expert group meeting on basic socio-economic assistance as precondition for effective drug dependence treatment and related HIV/AIDS prevention, Vienna, 12-14 May 2011**

I. Basic socio-economic assistance as a key component of UNODC drug prevention and treatment programmes

A. Drug dependence — a global public health issue

1. UNODC considers drug dependence a global public health issue that has a serious impact on development and security and that can be prevented and treated.[1] In this connection, UNODC strongly promotes recovery-oriented provision of prevention and treatment services for individuals affected by drug dependence and related HIV infection.[2] UNODC supports worldwide evidence-based laws, policies, strategies and interventions that champion public health and human rights, with a particular focus on low and middle income countries.

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[1] UNODC/WHO: Principles of Drug Dependence Treatment. Discussion Paper, March 2008.

[2] UNODC: From coercion to cohesion. Treating drug dependence through health care, not punishment. Discussion paper. September 2010.

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B. The Experts Group Meeting

2. On May 12-14, 2011, UNODC held a three-day Experts Group Meeting, entitled "Basic socio-economic assistance as a precondition for effective drug dependence treatment and related HIV/AIDS prevention". Participants were comprised of experts from industrialized, developing and least-developed countries. International experts present at the meeting included (i) practitioners who implement interventions in their daily work, including basic socio-economic assistance for individuals and communities affected by poverty, problem drug use and HIV infection; (ii) academics in the field of social science with research expertise in the fields of drug dependence, public health and development and (iii) representatives of international organizations active in the areas of nutrition, health, poverty-reduction and development. The objective of the meeting was to examine how interventions aimed at the alleviation of very basic needs arising from poverty can address and reduce problematic drug use and drug-related health risks. Outcomes of the meeting are to be used for future policy development.

3. UNODC wishes to express its appreciation to the participants of the Experts Group Meeting. As a result of their valuable contributions the realization of this conference room paper was made possible. The Secretariat wishes to thank in particular Dr. Julian Buchanan who edited the final report, based on which the conference room paper was prepared.

4. Based on the results of the Experts Group Meeting, the present paper advocates basic socio-economic assistance as a key component of UNODC's drug dependence and related HIV/AIDS prevention and treatment strategies. The main argument is that developing and promoting basic socio-economic assistance services to support individuals vulnerable to and affected by drug dependence and socio-economic marginalization is highly beneficial to successfully implement the drug supply and drug demand reduction strategies promoted by UNODC. Basic socio-economic services have an immediate positive effect on individuals vulnerable to or affected by drug dependence and related health risks. They could motivate the individual to gain trust and seek help and thereby reduce the likelihood of returning to the use of drugs and the associated risk behaviour.[3]

C. The concept of basic socio-economic assistance

5. Basic socio-economic assistance has been utilized in various contexts by the international development community to provide assistance to individuals affected by socio-economic marginalization and in humanitarian need. Services provided typically include immediate emergency social support, such as food distribution, health services, accommodation in safe and clean places and the provision of hygiene facilities and donation of clothes. The foremost objective of basic socio-economic assistance services is to ensure survival of individuals and decrease their suffering from hunger, disease, cold or heat, and danger. Additional goals are to enhance the quality of life and enable beneficiaries to be self-sufficient. Basic socio-economic assistance services are implemented with the objective of

[3] Marlatt, G.A., (2002) Harm Reduction: Pragmatic Strategies for Managing High-Risk Behaviors, Guilford Press.

strengthening protective factors that help guard against numerous vulnerabilities and high risk behaviours.

6. Evidence has shown that basic socio-economic assistance can be effective as an incentive for behaviour change, and make individuals chose healthier and less risky alternative options. Conditional cash transfers of sums that might be considered insignificant in a "Western" society, have been proven to be effective prevention tools for sexually-transmittable diseases. The result of a research entitled "The RESPECT study: Evaluating Conditional Cash Transfers for HIV/STI Prevention in Tanzania" conducted by the World Bank in cooperation with the University of California, Berkeley and the Ifakara Health Institute in Tanzania[4] provided evidence that young men and women in Tanzania were less vulnerable to sexually transmitted infections when provided with an amount equivalent to US$ 60 over a year, conditional on testing negative for a set of curable sexually transmitted infections. The study's results lead to the conclusion that individuals in dire circumstances might be responsive to incentives and change behaviour when basic assistance is provided and immediate needs are met, allowing them to overcome restraints created by their socio-economic situation.

7. A range of factors act as barriers that prevent individuals affected by drug dependence from accessing basic socio-economic assistance services they are in need of. Even in high and middle income countries, where basic socio-economic services are often provided for by the state, those drug dependent remain hard to reach and are vulnerable to neglection.[5] In developing and least developed countries, where socio-economic services are not available at all or provided by organizations of the international development community in cooperation with respective government agencies, the special needs of drug dependent individuals might not be considered a priority.

II. Practice and policy interventions: basic socio-economic assistance within a framework of drug demand reduction

A. Immediate benefit and protection

8. Tackling drug dependence requires an integrated approach that benefits the individual by respecting the person and promoting dignity. Therefore, strategies that encourage and enable service provision that will assist people to lead a dignified life free of danger, fear and health threats, and enable them to consider the engagement in a therapeutic alliance to tackle drug dependence are necessary. Incorporating basic socio-economic assistance in the context of services for drug dependence prevention and treatment supports a human rights based approach, which should be

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[4] de Walque D, WH Dow, R Nathan, R Abdul, F Abilahi, E Gong, Z Isdahl, J Jamison, B Jullu, S Krishnan, A Majura, E Miguel, J Moncada, S Mtenga, MA Mwanyangala, L Packel, J Schachter, K Shirima and CA Medlin. 2012. "Incentivising safe sex: A randomised trial of conditional cash transfers for HIV and sexually transmitted infection prevention in rural Tanzania." BMJ Open 2012;2:e000747. doi:10.1136/bmjopen-2011-000747. http://bmjopen.bmj.com/cgi/content/full/bmjopen-2011-000747.

[5] Mackridge, A.J. et al., (2010) Meeting the health needs of problematic drug users through community pharmacy: A qualitative study. Journal of Substance Use, 15, pp. 367-376.

a fundamental pillar of any national drug policy.[6] It is worth highlighting that the associated costs of failing to look after dependent drug users are much higher than the provision of basic socio-economic assistance. Investment in drug treatment results in cost savings.[7]

9. Individuals vulnerable to or affected by drug dependence and related HIV infection experience a direct and immediate benefit from basic socio-economic services. By receiving basic socio-economic assistance, affected individuals have access to services that they urgently need, ensuring survival by averting death from starvation, thirst, cold or a treatable disease. Through basic socio-economic assistance services, individuals, possibly the first time in their lives, experience care and attention, increase in overall well-being, and diminished suffering. As a result, beneficiaries might feel more dignified and are protected against further risk behaviour as, without basic socio-economic assistance, they might be forced to sleep on the street and might have to steal, sell drugs or engage in sex work to be able to buy food.

B. Recommended interventions

10. In order to implement basic socio-economic services as an effective component of drug demand reduction strategies, it is particularly important that socio-economic services are targeted to the particular needs of individuals vulnerable to or affected by drug dependence and related HIV infection, in close cooperation with institutions offering prevention and treatment. Basic socio-economic assistance as a strategic component of drug use prevention and drug dependence treatment should be available on a voluntary basis without additional sanctions or conditions attached to receiving treatment in order to create trust and reduce fear and suspicion. Coercive mandatory treatment with offenders has high rates of drop-out and reconviction and has not proven to be particularly effective.[8] To reach the most vulnerable, services will need to pro-actively seek out long-term dependent drug users. This outreach work is ideally carried out by well-trained and supported recovered drug users who have first-hand experience and understanding of the stigma, needs and problems faced, and who can often more easily develop a trusting relationship.[9]

11. The following services are recommended:

(a) Food distribution: Food distribution should be carried out in drop-in centres that are affiliated with drug use prevention and drug dependence treatment

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[6] Buchanan, J. & Young, L. (2000) Problem Drug Use, Social Exclusion and Social Reintegration – the client speaks in Greenwood G & Robertson K (eds.) Understanding and responding to drug use: the role of qualitative research pp. 155-161 EMCDDA, Lisbon; Keane, M. (2007) Social reintegration as a response to drug use in Ireland, Health Research Board, Dublin.

[7] Davies, L. et. al., (2009) The Drug Treatment Outcomes Research study (DTORS): Cost-effectiveness analysis. Research, Development and Statistics Directorate, Home Office, London.

[8] Bennett, T. & Holloway, K., (2010) Is UK drug policy evidence based? International Journal of Drug Policy, 21, (5) pp. 411-417; Parhar, K.K. et al., (2008) "Offender Coercion in Treatment", Criminal Justice and Behavior, 35, (9) pp. 1109 -1135.

[9] Hayashi, K. et al., (2010) "An external evaluation of a peer-run outreach-based syringe exchange in Vancouver", Canada. International Journal of Drug Policy, 21, (5) pp. 418-421.

opportunities. Food should be provided with the objective to restore the body with vitamins and essential carbohydrates, proteins, fats and acids that not only help rebuilding physical strength but also improve the mental capacity, concentration and avoid psychological problems, such as depression. For full recovery, it is important that nutritional reserves that are depleted from years of suffering, dependence and ill health are re-supplied.

Health-care services should include provision of special nutrition if needed in case of medical necessity. Individuals recovering from drug dependence who are vulnerable to malnutrition should be provided food that is high in nutrients and helps rebuild damaged tissues and regain appropriate functioning of the systems and organs of the human body. This includes food that can easily be digested and/or has a higher nutritional value to help HIV infected drug users gain the most benefit from antiretroviral treatment.[10] When receiving treatment for AIDS, highly nutritious food is particularly important as well. Ideal absorption of the medication by the body and positive effects can only occur when the patient is well nourished.

(b) Safe and clean shelter: In order to ensure protection from morbidity and risk behaviour when living on the street, individuals vulnerable to and affected by drug dependence and related HIV infection must have access to safe and clean sleeping places where supervision is provided, individual space is available and where the use of drugs is tolerated. Adequate housing is necessary to create an environment where the individual can feel safe and protected, enabling him or her to consider engaging in a therapeutic alliance.

(c) Basic medical assistance and health education: Medical check-ups should be provided regularly through outreach as well as drop-in work with the aim of determining and regularly updating the status of the individuals' health, ensuring access to necessary treatment and medication to avoid further health deterioration. The relief of pain should be a priority for medical assistance as well. This way, individuals can (re)gain a dignified feeling, hope, trust, and consider engaging into a therapeutic alliance for drug dependence treatment. To this end, nurses and doctors should be available in drop-in centres and accompany outreach work. Contacts with hospitals should be facilitated in case of suspicion of a disease that requires stationary treatment.

Basic health care should include health education for the target group, focusing on preventing major risks and contributing to the protection of one's own health as well as those of peers and sexual partners.[11] Training on the use and dosage of basic pain medication must be a component of related training as well as knowledge about the dangers of drugs and the infection with blood-borne diseases. In addition, it is important that medication for possible side effects of drug dependence treatment and HIV/AIDS treatment is available.

(d) Donation of clothes and provision of hygiene facilities: In order to give affected individuals a dignified feeling, it is important that they have access to basic hygiene facilities and that they are equipped with a basic set of clean clothes.

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[10] Johannessen, A. et al., (2008) "Predictors of mortality in HIV-infected patients starting antiretroviral therapy in a rural hospital in Tanzania", BMC Infectious Diseases, 8, (1) p. 52.

[11] Convey, M.R. et al., (2010) "Altruism and Peer-Led HIV Prevention Targeting Heroin and Cocaine Users", Qualitative Health Research, 20, (11) pp. 1546 -1557.

People should be allowed to come to the drop-in centres to take showers. Hygiene kits for people that are hesitant to stay at the shelters should be provided additionally.

12. When individuals benefit from basic socio-economic services regularly, the additional benefit of decreasing other health and social risks, such as violence, life on the street, health risks, sex work, criminalisation and incarceration is added to the aspect of initial protection. Basic socio-economic services enable affected individuals to benefit more effectively from prevention and treatment, and as a consequence contribute to lower rates of relapse, and decreases the risk of contracting and spreading blood-borne diseases. In most cases, basic socio-economic assistance enables the individual to actually consider taking part in prevention and treatment activities. Not having to worry about food any more, not suffering any more from pain, the individual might develop trust towards service-providers, feel dignified and realize that treatment might be possible.

C. Additional requirements

(a) Special provisions for women: Particular woman-sensitive interventions[12] should be part of basic socio-economic interventions for drug dependent individuals. This should include safe women-only spaces, peer support from other women, child care facilities and access at suitable times and places. The ongoing development of gender sensitive services for women should be led by women.[13] In addition, women who are pregnant, drug dependent and possibly infected with HIV or living with AIDS should be offered services that can help prevent mother to child transmission upon delivery.[14] Arrangements for care for children of mothers that undergo treatment as well as for babies that are born physically addicted should be in place and be provided in a way that builds the mother-child relationship.

(b) Fighting stigma and discrimination: Basic socio-economic interventions can only be successful and have a sustainable impact when social exclusion and stigma against drug dependent individuals and people living with AIDS or HIV infection is decreased. Therefore, awareness raising campaigns should be considered to protect the human rights of people dependent on drugs and present them as people in need of help and care rather than as criminals that have to be arrested and punished.[15] Punishment and compulsory measures should have no place in drug treatment.[16]

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[12] El-Bassel, N., Terlikbaeva, A. & Pinkham, S., (2010) “HIV and women who use drugs: double neglect, double risk”, The Lancet, 376, pp. 312-314.

[13] The Global Coalition on Women and AIDS (2011) Women who use drugs, harm reduction and HIV, Geneva, Switzerland www.womenandaids.net/news-and-media-centre/latest-news/women-who-use-drugs--harm-reduction-and-hiv.aspx.

[14] Padian, N.S. et al., (2011) “HIV prevention transformed: the new prevention research agenda”, The Lancet, 378, pp. 269-278.

[15] Tindal, C., Cook, K. and Foster. N. (2010) “Theorising stigma and the experiences of injecting drug users in Australia.” Aust. J. Primary Health 16(2) pp. 119-125.

[16] Parhar, K. K. et al., (2008) “Offender Coercion in Treatment”, Criminal Justice and Behavior, 35(9), pp. 1109 -1135.

There is a need for mainstream interventions to assist dependent drug users in recovery to re-orientate their life and become better equipped to reintegrate and participate in the local community.[17] Interventions must work to improve the self-esteem of individuals suffering from drug dependence in order to develop the confidence to actively engage within non-drug using environments, where the individual may continue to face discrimination or marginalization as a result of their histories of drug use.

D. Inter-agency cooperation and community participation

13. Basic socio-economic assistance services for individuals affected by drug dependence and related HIV infection should be implemented within a framework of broad inter-agency cooperation and with a strong component of community-participation. Shared recognition of the strong inter-linkage of drug dependence and social and health risk behaviour and a philosophical collaboration and commitment across all major agencies (social care, health and enforcement) to see individuals with drug dependence as people with health and social needs rather than criminals in need of punishment, is a key predictor for success.

(a) Inter-organizational cooperation should be strengthened, specifically focusing on human and societal development and education. Partnerships with the United Nations Children's Fund (UNICEF), the United Nations Development Programme (UNDP), the World Food Programme (WFP), the United Nations Food and Agricultural Organization (FAO) and the World Health Organization (WHO) are recommended in order to add value to the components of education, protection of vulnerable children, nutrition and food, basic medical assistance and humanitarian service delivery.

(b) On the national level, strong partnerships should be developed and stakeholders should be approached on the governmental, institutional and grassroots level. All key agencies involved with social issues, health and the justice system, including police, law enforcement, social care agencies and the voluntary sector must be key partners in project implementation and committed to work together in partnership. National ownership and leadership from the top down is crucial and should be accompanied by a shared policy and practice commitment.

(c) The involvement of, and commitment from the community at a local level is needed. Local municipalities should be included in a community-based approach of the planning and implementation of activities, as a regional focus is important for success that cannot be achieved by the national government alone. Strengthening coordination with civil society organizations, non-governmental organizations, contact persons in schools, universities, hospitals, private and public institutions must be sought as key partners for the incorporation of basic socio-economic assistance in prevention and treatment programmes.

(d) A commitment to involve people who are suffering from drug dependence as well as those who have recovered is strongly recommended. Including affected individuals as staff members in organizations that deliver basic-

[17] Buchanan, J. (2004) "Tackling Problem Drug Use: A New Conceptual Framework", Journal of Social Work in Mental in Health, 2, (2/3) pp. 117-138.

socio economic services to individuals affected by drug dependence and related HIV infection builds trust initially and serves as a strong foundation for a relationship facilitating increased access to low threshold services.

III. The socio-economic context of drug dependence

A. Socio-economic context of drug dependence and related HIV infection

14. As long as individuals affected by drug dependence and related HIV infection continue to live in marginalized socio-economic situations, suffering from poverty, unemployment, lack of decent housing, community breakdown and restricted opportunities for education and making a living, the vicious circle of deprivation, drug dependence and related ill-health will persist. When the socio-economic situation encompassing drug dependent individuals is not altered by external assistance, it is foreseeable that relapse will occur after treatment has been provided and that high numbers of new infections occur although prevention is provided. Key factors that influence persistent drug use may be the environments in which risk is produced rather than individual-level factors.[18]

15. There is not a direct and linear causality between a marginalized socio-economic context and drug dependence but evidence has shown that a strong interconnectedness does exist, although the precise nature of that relationship is complex.[19] In low income countries with limited or no social welfare services, but also in some high income countries, impoverished individuals are vulnerable to dire humanitarian conditions. In these very difficult circumstances, individuals might have no choice than to live on the streets, without being able to meet basic needs and without access to hygiene facilities and safe shelter and not being able to buy sufficient food and appropriate clothes. In such an environment, when drugs are easily accessible at low-cost, they are often perceived as a last resort, providing respite from hopelessness.[20]

16. The impact of a drug centred lifestyle often undermines the person's capacity to engage in the daily routines of life, such as work, cooking, proper eating, daily hygiene and socializing with friends and family.[21] Marginalized individuals with

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[18] Nandi, A. (2010) "Neighborhood Poverty and Injection Cessation in a Sample of Injection Drug Users", American Journal of Epidemiology, 171, (4) pp. 391-398.

[19] Foster, J. (2000) "Social exclusion, crime and drugs", Drugs: Education, Prevention and Policy, vol. 7, No. 4, pp. 317-330; Room, R. (2005) "Stigma, social inequality and alcohol and drug use", Drug and Alcohol Review, 24, (2) pp. 143-155; Nasir, S. and Rosenthal, D. (2009) "The social context of initiation into injecting drugs in the slums of Makassar, Indonesia", International Journal of Drug Policy, 20, (3) pp. 237-243; Seddon, T. (2006) 'Drugs, Crime & Social Exclusion: Social context and social theory in British Drugs – Crime research.' British Journal of Criminology 46, (4) pp. 680-703.

[20] McNaughton, C.C., (2008) "Transitions through homelessness, substance use, and the effect of material marginalization and psychological trauma", Drugs: Education, Prevention, and Policy, 15, pp. 177-188; Buchanan, J. & Young, L. (2000) 'The War on Drugs – A War on Drug Users' in Drugs: Education, Prevention Policy, Vol. 7 No.4 pp. 409-422.

[21] Kemp, P. and Neale, J. (2005) 'Employability and problem drug users', Critical Social Policy 25, (1) pp. 28-46.

limited legitimate sources of income who loose control over their drug habit and become enmeshed in a drug centred lifestyle are often drawn into pursuing illegal or risky sources of income such as sex work, theft, burglary, robbery, drug cultivation and drug dealing.[22] The effects of drug intake, withdrawal symptoms and a drug centred lifestyle aggravate the ability to take care of personal health, hygiene and nutrition and negatively impact on general well-being.[23] Individuals struggling to survive and pre-occupied with drug dependence may consider taking care of their health and protecting themselves and others against the infection from blood-borne diseases a low priority.[24] To avoid psychological and physical withdrawal symptoms, a drug dependent person engages in a daily cycle of planning including money acquisition to fund the drug habit. This demanding and relentless lifestyle driven by drug dependence results in further isolation and marginalisation, it leaves no room for any other endeavour and the person becomes trapped within a sub-culture with limited opportunities to exit.[25]

17. The drivers towards a drug centred lifestyle begin early during childhood and adolescence in the lives of most individuals suffering from long-term drug dependence. Growing up poor with limited opportunities in education and employment are typical constituents in the life of drug dependent individuals.[26] Negative experiences in early life, such as disrupted and unsettled family situation, continuous economic stress, relational conflict and neglect all negatively influence personal development, self-esteem and achievements and make the transition to adulthood problematic.[27] Studies have shown that individuals which such a background often become over- represented in prisons and drug treatment services in their later life.[28]

B. Health vulnerabilities related to drug use and dependence

18. Individuals with serious mental health problems may use illicit drugs to 'self-medicate' to enable them to cope with mental health needs.[29] Problem drug use

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[22] Buchanan, J. & Young, L. (2000). "The War on Drugs; A war on drug users?" Drugs: Education, Prevention, and Policy, 7, pp. 409-422; Buchanan, J. (2006) 'Understanding Problematic Drug Use: A Medical Matter or a Social Issue', British Journal of Community Justice, 4, (2) pp. 387-397.

[23] McNaughton, C.C. (2008) Transitions through homelessness, substance use, and the effect of material marginalization and psychological trauma. Drugs: Education, Prevention, and Policy, 15, pp. 177-188.

[24] Piot, P. et al., (2008) "Coming to terms with complexity: a call to action for HIV prevention", The Lancet, 372, (9641) pp. 845-859.

[25] Room, R. (2005) "Stigma, social inequality and alcohol and drug use', Drug and Alcohol Review, Vol. 24, No. 2, pp. 143-155; Buchanan, J. (2004) "Tackling Problem Drug Use: A New Conceptual Framework", Journal of Social Work in Mental in Health, 2 (2/3) pp. 117-138.

[26] ACMD (2006) 'Pathways to Problems: Hazardous use of Tobacco, Alcohol and Other Drugs by Young People in the UK and its Implications for Policy', Advisory Council on the Misuse of Drugs, London.

[27] Melrose, M. (2004) "Fractured transitions: Disadvantaged young people, drug taking and risk." Probation Journal, 51, (4) pp. 327-341.

[28] Buchanan, J. (2004) "Missing links? Problem drug use and social exclusion." Probation Journal 51, (4) pp. 387-397.

[29] Harris, K. M. and Edlund, M. J. (2005) "Self‐Medication of Mental Health Problems: New Evidence from a National Survey." Health Services Research 40, (1) pp. 117-134.

and poor physical and mental health are often closely related and can mutually intensify each other.[30] Problem drug use and poor physical and mental health are often closely related and can mutually intensify each other.[31] The demand for illicit drugs might be driven by an inability to access basic medical care. Where medical assessments and pharmaceutical remedies are difficult to obtain and where qualified medical treatment is out of reach, individuals are vulnerable to using illicit drugs use as a means of self medication. Individuals may consume drugs to decrease suffering from hunger or take drugs for pain relief or sickness — when given to young children it has caused overdose and even death.[32]

19. Drug dependence treatment and medication for individuals infected with HIV and living with AIDS might have side effects that require additional medication. If such medication is not available, individuals might suffer from secondary effects to an extent that makes continuation of treatment impossible.

20. Drug dependent individuals are vulnerable to risk behaviour, i.e. sex work, sharing needles, and therefore the danger of infection with HIV and other blood-borne diseases increases.[33] Affected individuals may be unaware of the risks associated with their behaviour and don't have contact where they could obtain advice, equipment and services to reduce the risks accompanying drug use.[34] In addition, craving for drugs and suffering from withdrawal symptoms might be so strong and overwhelming that health risks are faded out of the perception of the individual affected by drug dependence.

C. Shortcomings regarding nutrition

21. Individuals affected by drug dependence often lack a proper diet, as drug intake takes precedent and some drugs decrease appetite.[35] Due to economic shortage the individual is less likely to have the financial capacities to buy good quality nutritious food. Dehydration is also a common health problem of drug consumption resulting from neglecting nutrition as well as drug side effects. Malnutrition is known to weaken the immune system, which may lead to greater risk of infection with blood-borne diseases, an aggravated disease progress and other adverse health outcomes.[36]

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[30] Rassool, G. Hussein. (2002) Dual diagnosis: substance misuse and psychiatric disorders. Wiley-Blackwell.

[31] Rassool, G. Hussein. (2002) Dual diagnosis: substance misuse and psychiatric disorders. Wiley-Blackwell.

[32] Besharat, S., Jabbari, A., and Besharat. M., (2008) "Opium as a fatal substance." The Indian Journal of Pediatrics 75 pp. 1125-1128.

[33] Henry J. Kaiser Family Foundation (2002) Survey Snapshot: Substance Use and Risky Sexual Behavior: Attitudes and Practices Among Adolescents and Young Adults, www.kff.org/youthhivstds/upload/KFF-CASASurveySnapshot.pdf.

[34] Wood, E. et al., (2008) "A review of barriers and facilitators of HIV treatment among injection drug users", AIDS, 22, pp. 1247-1256.

[35] Neale, J, Nettleton, S., Pickering, L. and Fischer, J. (2011) "Eating Patterns Amongst Heroin Users: A Qualitative Study with Implications for Nutritional Interventions." Addiction. http://onlinelibrary.wiley.com/doi/10.1111/j.1360-0443.2011.03660.x/abstract.

[36] Forrester, J.E., Woods, M. N., Knox, T. A., Spiegelman, D., Skinner, S. and Gorbach, S.L., (2000) Body Composition and Dietary Intake in Relation to Drug Abuse in a Cohort of

22. A person that is undergoing drug dependence treatment and does not have access to adequate nutrition is more vulnerable to drug relapse. He or she might experience low general well-being and depending on the respective environment, it might be possible that drugs are easier to obtain than healthy food. Individuals recovering from drug dependence typically have a greater interest in food and an improved appetite. Blood-glucose levels of individuals recovering from drug dependence can vary considerably and nutrition is needed to counteract the risks.[37]

23. Drug dependence treatment medication as well as HIV/AIDS medication increase need for nutrition.[38] Antiretroviral treatment for HIV infected individuals cannot be ingested on an empty stomach, because digestion will not possible and the patient will suffer unbearable pain.[39] A malnourished person's body cannot absorb medication and no positive effect will incur. If nutrition is not foreseen by service-providers, individuals may not be able to benefit neither from drug dependence nor HIV/AIDS treatment because they cannot bear the additional costs of buying more food.[40] Nutritional deficits also occur as a consequence of drug dependence and when recovering and undergoing treatment.

D. Stigma and discrimination

24. In some countries, criminalization of drugs users has resulted in repressive policies,[41] which makes any attempt to provide socio-economic assistance to drug dependent individuals highly problematic, because such action could be interpreted as providing assistance to benefit individuals engaged in illicit behaviour. Criminalization, harsh penal sanctions and hostility towards individuals dependent on illicit drugs fuel stigma and exclusion towards known drug users[42] and undermine progress on health, human rights and also hinder progress towards

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HIV-Positive Persons. Journal of Acquired Immune Deficiency Syndromes. 5, (Suppl 1) pp. S43-S48; Forrester, J.E., Tucker K.L., Gorbach, S.L., (2004) Dietary intake and body mass index in Hispanics with and without HIV infection. Public Health Nutrition, 7 (7) pp. 863-870; Islam, N., Hossain K.J., and Ahmed, A., et al., (2002) Nutritional status of drug addicts undergoing detoxification: prevalence of malnutrition and influence of illicit drugs and lifestyle. British Journal of Nutrition. 88: pp. 507-513; Smit, E., Graham, N.M.H., and Tang A., (1996). Dietary intake of community based HIV-1 seropositive and seronegative Injecting drug users. Nutrition, 12 (7-8) pp. 496.

[37] Neale, J, Nettleton, S., Pickering, L. and Fischer, J. (2011) "Eating Patterns Amongst Heroin Users: A Qualitative Study with Implications for Nutritional Interventions." Addiction. http://onlinelibrary.wiley.com/doi/10.1111/j.1360-0443.2011.03660.x/abstract.

[38] Tang, A.M. et al., (2011) "Malnutrition in a population of HIV-positive and HIV-negative drug users living in Chennai, South India", Drug and Alcohol Dependence, 118, (1) pp. 73-77.

[39] How did it come to this?" The Guardian, 13 February 2009.

[40] Mukherjee, J.S. et al., (2006) 'Antiretroviral Therapy in Resource-Poor Settings', JAIDS Journal of Acquired Immune Deficiency Syndromes, 43, pp. S123-S126.

[41] Jürgens, R., Csete, J., Amon, J.J., Baral, S. and Beyrer, C. (2010) "People who use drugs, HIV, and human rights." The Lancet 376, (9739) p. 475-485; Edwards, Griffith et al. (2009) "Drug Trafficking: Time to Abolish the Death Penalty." Journal of Groups in Addiction & Recovery 4 p. 322-326.

[42] Wood, E. et al., (2010) "Vienna Declaration: a call for evidence-based drug policies", The Lancet, 376, pp. 310-312.

meeting Millennium Development Goals.[43] Individuals affected by drug dependence might fear from admitting they have a drug problem, making both giving up drugs and staying off drugs more difficult and reducing the effectiveness of existing drug prevention and treatment services. Victims of drug dependence constantly have to wary of disclosing their status for fear of criminalization and stigma.

25. Drug dependent individuals who experience discrimination are vulnerable to internalise the social stigma and diminish their expectations in respect of recovery. This stigmatisation of people with drug problems[44] contributes to them living in relative isolation from mainstream society and can have a detrimental effect upon their mental health and well being.[45] Affected individuals struggle to engage in reciprocal and mutually beneficial exchange of social capital. Social capital and informal structures are crucial for socio-economic security in low-income regions where no government social support system is available. Relationships in these informal structures are built upon trust, which results from continual engagement, participation and interaction - aspects of daily life that may be denied to people that are not in a position to reciprocate.[46]

E. Special needs of women

26. Women are exposed to special vulnerabilities as their traditional roles as care givers as well as their relatively lower physical defence capacities create additional risk factors. In particularly dire situations of humanitarian need, women might not see an alternative to engage in sex work due to a lack of alternative options to secure survival. When in severe economic need, women might consider engaging in relationships with men mainly because they hope they would care for them and are at risk of being caught in an abusive relationship where they might be physically abused, raped and/or forced to engage in sex work. Faced with such difficult circumstances some women may see illicit drugs as a way to ease pain and loss of dignity and become even more vulnerable to drug dependence and related HIV infection.[47]

27. When a family separates in a majority of cases the woman takes care for the children. Women are particularly vulnerable to unwanted pregnancy in underprivileged socio-economic contexts and when engaging in sex work to obtain money for drugs. Becoming a single parent family often impacts negatively upon income, and can expose the family to serious poverty. Confronted with additional

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stigma, marginalization and fear, it is possible that women might hide their drug problem and related HIV infection and not seek help at all. They might also fear that their children are taken away from them when their drug dependence is disclosed. For the same reason, women might also seek to hide their pregnancy and prefer to give birth clandestinely, fearing that the child might be taken from them after delivery, without undergoing therapy that prevents mother-to-child transmission of HIV in case of HIV infection.

IV. Conclusion

28. As has been demonstrated, the inclusion of basic-socio-economic assistance services can contribute to increasing the effectiveness and sustainability of prevention and treatment strategies for drug dependence and related HIV infection. It has been demonstrated why an individual that has been affected by poverty and social exclusion, drug dependence and related ill health is not in a position to lead a new life free of risk without external support and assistance. Socio-economic support that is tailored to the particular needs of this specific target group should be considered a priority in the healthcare activities of any country. Member states should consider that treatments as well as the implications for the society are more costly than sustainable prevention and care.

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