United States

We Know What to Do

Harm Reduction and Human Rights in North Carolina

HUMAN RIGHTS WATCH

ADVOCACY BRIEF

We Know What to Do

Harm Reduction and Human Rights in North Carolina

When President Barack Obama unveiled the National HIV/AIDS Strategy in July 2010, he identified a public health imperative to tackle the HIV/AIDS epidemic and cut the country's annual number of new infections by 25 percent over the next five years. The strategy has three goals: to prevent new HIV infections, increase access to HIV care and treatment, and reduce HIV-related health disparities. The challenge, as the president indicated, was not a lack of insight as to what steps to take—we know what to do—but rather whether action would be taken to address the problem.

"[T]he question is not whether we know what to do, but whether we will do it. Whether we will fulfill those obligations; whether we will marshal our resources and the political will to confront a tragedy that is preventable," the president told a White House reception on July 13, 2010.[1]

For many years, it has been well documented in the US and globally that one way to prevent HIV transmission—and also hepatitis C, an infectious disease that infects the liver—is to increase access to sterile syringes.[2] The National AIDS Strategy endorses access to sterile needles and syringes as a "scientifically proven" method for reducing HIV transmission, while recognizing the higher risk of HIV for black and Latino drug users, and calling for focused interventions within those populations that need them most.[3] The World Health Organization has recommended that syringe exchange programs reach at least 60 percent of injection drug users to effectively control HIV.[4]

Syringe exchange is part of an approach known as harm reduction, in which policies, programs and practices aim to reduce or prevent the harm associated with drug use and

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[1] "Remarks by the President on the National HIV/AIDS Strategy," The White House Office of the Press Secretary, July 13, 2010, http://www.whitehouse.gov/the-press-office/remarks-president-national-hivaids-strategy (accessed June 15, 2011).

[2] World Health Organization (WHO), Joint United Nations Programme on HIV/AIDS (UNAIDS), United Nations Office on Drugs and Crime (UNODC), *Policy Brief: Provision of Sterile Injecting Equipment to Reduce Transmission of HIV,* (Geneva) 2004; Hurley, et al, "Effectiveness of needle exchange programmes for the prevention of HIV infection," The Lancet, Vol. 349, June 21, 1997: 1797-1800.; Burris, S., Substance Abuse Policy Research Program, *Policy Brief on Needle Exchange,* January 2009; Office of National AIDS Policy, "National HIV/AIDS Strategy for the United States," July 2010, p. 6.

[3] National HIV/AIDS Strategy, pp. 16, 21

[4] WHO, UNODC, UNAIDS, *Technical Guide for countries to set targets for universal access to HIV prevention, treatment and care for injecting drug users*, (Geneva), 2009.

other potentially harmful behaviors. Harm reduction measures, which are common in other countries, make injection drug use the *only* mode of HIV transmission that has shown long-term, consistent decline since the epidemic began.[5]

Although harm reduction is common practice in other countries and has proved to be successful, the US remains woefully behind in implementing these approaches, primarily due to the "war on drugs" that takes a punitive rather than a public health approach to drug use.[6] Indeed, syringe exchange programs are only providing enough clean needles for 3 percent of the approximately one billion drug use injections that occur annually in the United States.[7]

Implementing harm reduction practices widely in the US is not just sound public health policy, it is a human rights imperative that requires strong federal and state leadership. It is also consistent with the key international treaty, which the US has signed, which protects the right to health and has been interpreted to require that governments ensure, at a minimum, a range of harm reduction interventions including syringe programs, opioid substitution therapy, overdose prevention, and harm reduction services for youth, prisoners and other vulnerable groups.[8]

Yet in too many states, misguided laws and policies block harm reduction and prevent drug users from accessing sterile syringes that can save their lives. One such state is North Carolina.

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[5] National HIV/AIDS Strategy, p. 6.

[6] Global Commission on Drug Policy, "War on Drugs: Report of the Global Commission on Drug Policy," June 2011, available at http://www.globalcommissionondrugs.org/Report (accessed August 26, 2011); Burris, S., et al," Racial Disparities in Injection-related HIV: Case Study of Toxic Law," *Temple University Law Review*, 82: 1263-1307 (2010); Drug Policy Alliance, "After the Drug War: Toward a Health and Public Safety Approach," March 28, 2011, http://www.drugpolicy.org/resource/after-drug-war-toward-health-and-public-safety-approach (accessed August 26, 2011); Blankenship, KM et al., "Black-White Disparities in HIV/AIDS: The Role of Drug Policy and the Corrections System," *Journal of Health Care for the Poor and Underserved*, vol. 16, no. 4, 2005, p.140-146.

[7] Burris, S., et al," Racial Disparities in Injection-related HIV," p. 1281-1285.

[8] International Covenant on Economic, Social and Cultural Rights (ICESCR), adopted December 16, 1966, G.A. Res. 2200A (XXI), 21 UN GAOR (no. 16) at 49, UN Doc. A/6316 (1966), 99 UNTS 3, entered into force January 3, 1976, signed by the United States on October 5, 1977, articles 2, 12. See, General comment No. 14, The Right to the Highest Attainable Standard of Health, Committee on Economic, Social and Cultural Rights, 22nd Session, 2000. The UN Committee on Economic, Social and Cultural Rights has interpreted the article 12 of the Covenant on Economic, Social and Cultural Rights to require, at a minimum, that states ensure a range of harm reduction interventions, including needle and syringe programs; opioid substitution therapy; overdose prevention; youth focused harm reduction services; and prison harm reduction. See Committee on Economic, Social, and Cultural Rights (CESCR) concluding observations for Russia (2011), para 29; Tajikistan (2006); UN Doc No E/C.12/TJK/CO/1 para 70. Ukraine (2007), UN Doc No E/C.12/UKR/CO/5 paras 28 and 51.; Poland (2009); Kazakhstan (2010); Mauritius (2010). While not binding on the U.S., which has yet to ratify the ICESCR, this interpretation should be taken as an important interpretive guidance to the general human rights obligation to ensure adequate medical care and social services to protect health.

WHAT IS HARM REDUCTION?

Harm reduction is a way of preventing disease and promoting health that "meets people where they are" rather than making judgments about where they should be in terms of their personal health and lifestyle. Accepting that not everyone is ready or able to stop risky or illegal behavior, harm reduction focuses on promoting scientifically proven ways of mitigating health risks associated with drug use and other high risk behaviors, including condom distribution, access to sterile syringes, medications for opioid dependence such as methadone and buprenorphine, and overdose prevention.

Emphasizing public health and human rights, harm reduction programs provide essential health information and services while respecting individual dignity and autonomy. For drug users, harm reduction recognizes that many drug users are either unable or unwilling to stop, do not need treatment, or are not ready for treatment at a given time. Harm reduction programs focus on limiting the risks and harms associated with unsafe drug use, which is linked to serious adverse health consequences, including HIV transmission, viral hepatitis, and death from overdose.

"The help I got from the harm reduction program was more than just clean equipment, it was about being with people who didn't judge me for my addiction, and who really wanted to help."[9]

—Sam, a 50-year-old former drug user and sex worker in Carrboro, NC

Harm reduction programs have been shown to lower HIV risk and hepatitis transmission, prevent overdose, and provide a gateway to drug treatment programs for drug users by offering information and assistance in a non-judgmental manner.[10] Harm reduction also protects law enforcement officers from needle stick injuries—accidental pricks to the skin from handling hypodermic needles.[11]

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[9] North Carolina Harm Reduction Coalition, "The Need for Syringe Exchange: Interview with Sam, Person of Transgender Experience and Former Heroin User," June 2, 2011.

[10] World Health Organization, *Evidence for action technical papers: Effectiveness of sterile needle and syringe programming in reducing HIV/AIDS,"* Geneva: World Health Organization, 2004. See also, Ritter, A. & Cameron, J. "A review of the efficacy and effectiveness of harm reduction strategies for alcohol, tobacco and illicit drugs," *Drug & Alcohol Review,* vol. 25, no. 6, 2006, p. 614-619;

Hagan, et al., "Reduced injection frequency and increased entry and retention in drug treatment associated with needle-exchange participation in Seattle drug injections," *Journal of Substance Abuse Treatment*, vol. 19, no. 3, p. 247-250.

[11] Groseclose, S.L. et al., "Impact of increased legal access to needles and syringes on practices of injecting-drug users and police officers—Connecticut, 1992-1993," *Journal of Acquired Immune Deficiency Syndromes & Human Retrovirology*, vol. 10, no. 1, 1995, p. 82–89. McCampbell , SW & Rubin PN, "A needle exchange program: What's in it for police?," *Police Executive Research Forum*, vol 14, no. 10, 2000.

By providing safe disposal of injection equipment, harm reduction programs reduce the number of contaminated syringes circulating in a community.[12]

An outreach worker demonstrates use of a rubber mouthpiece for a crack pipe in Durham, NC. ©2011 Hadley Gustafson

Important principles of harm reduction programs include:

- A **non-judgmental** approach that treats every person with dignity, compassion, and respect, regardless of circumstance or condition;
- Utilizing **evidence-based, feasible,** and **cost-effective** practices to prevent and reduce harm;
- Accepting behavior change as an **incremental process** in which individuals engage in self-discovery and transition through "stages of change;"
- **Active and meaningful participation** of drug users, former drug users, and community stakeholders in shaping sensible policies and practices around drug use;
- Focusing on **enhancing quality of life** for individuals and communities, rather than promoting cessation of all drug use;

[12] Doherty MC, et al., "Discarded needles do not increase soon after the opening of a needle exchange program," *American Journal of Epidemiology*, vol. 145, no. 8, 1997, p. 730–7.

- Recognizing **complex social factors** that influence vulnerability to drug use and drug-related harm, including poverty, social inequality, discrimination, and trauma;
- **Empowering** drug users to be the primary agents in reducing the harms of their drug use;
- Commitment to defending **universal human rights.**[13]

Harm reduction encompasses a broad range of activities and interventions designed to improve the health and quality of life of individuals and communities. These include:

- Outreach and peer education to reduce risks associated with drug use;
- Needle and syringe exchange programs (SEPs);
- Opioid substitution therapies (OST) for drug dependence, including methadone and buprenorphine;
- Confidential counseling and testing for HIV, hepatitis, and other sexually transmitted or bloodborne infections;
- Wound care;
- Overdose prevention activities, including Naloxone (a prescription drug to prevent overdose) and first aid training;
- Provision of primary care and treatment for HIV and other sexually transmitted or blood-borne infections;
- Referrals to drug treatment programs.

[13] Harm Reduction Coalition (HRC), "Principles of Harm Reduction," (undated), http://harmreduction.org/section.php?id=62 (accessed June 2, 2011).

LINDA'S STORY

Linda, a 35-year-old woman, lives with her mother and her 14-year-old daughter in a wealthy neighborhood in Greensboro. Linda has bipolar disorder, and at age 13 started what she calls "chaotic drug use." She was hospitalized at 28 and entered long-term treatment. During those years, Linda stopped using drugs, finished college, and started a master's degree. She also started to work with drug users through local community outreach groups. Then she relapsed.

"Methadone didn't save me from addiction, but it helped me to use less, and it really helped me with my bipolar symptoms."

Linda believes many drug treatment programs fail drug users by promoting total abstinence from drugs as the only option. "Under the abstinence model, if you are not totally successful, you are considered a failure. So it gives you an excuse to continue to destroy yourself," she said.[14] "When I relapsed, I was devastated because I was told I had lost it all. So I fulfilled that prophecy, and I did lose it all, going downhill fast."[15] The narrow focus on abstinence causes many treatment centers to operate as "recycling centers," where drug users repeatedly cycle in and out. "I feel so much blame and shame in the abstinence approach," Linda explained. "Get 'clean' is a terrible term. It encourages the self-loathing that does not help people improve their lives."[16]

"Clean syringes don't sit around on a shelf…they are all put to good use."

Harm reduction services helped Linda cope with her relapse. Methadone alleviated her symptoms of withdrawal and increased her ability to function at school. "Methadone didn't save me from addiction, but it helped me to use less, and it really helped with my bipolar symptoms," she said.[17] Linda believes in harm reduction and has seen it save lives. Though pharmacies in North Carolina supply sterile injection equipment, most injection drug users have difficulty purchasing syringes at the pharmacy. "They get rejected once for being black, or for 'looking bad,' and they never go back," Linda explained.[18] "Drug users prefer a clean sharp

[14] Human Rights Watch Interview with Linda V. (pseudonym used to protect confidentiality), Greensboro, North Carolina, April 11, 2011.

[15] Ibid.

[16] Ibid.

[17] Ibid.

[18] Ibid.

needle; it hurts less and makes less of a tear in the vein. Clean syringes don't sit around on a shelf like condoms; they are all put to good use," she said.[19]

Update: Linda Arrested for Harm Reduction Activities

On June 23, 2011, Linda was arrested by the Guilford County Sheriff's Office. Multiple charges were brought against her, including felony charges related to distributing sterile injection supplies. At the time of her arrest, Linda was taking methadone by prescription. When she was taken to Guilford County jail, she was forced to go through withdrawal from methadone "cold turkey." This process can be as painful as withdrawal from heroin, and denying tapering or adequate medication is inconsistent with recommended medical practice and human rights law.[20] "It was seven days of hell. I was very, very sick," she said.

All of the charges against Linda are violations of her parole. Though she faces possible prison time due to her prior record of arrest for drug use, she is more concerned about the people who need her help. "This is bigger than me. My concern is that people won't get what they need. I know that having a history makes it risky for me to do this work, but this is work that is best done by people who have a history."

[19] Ibid.

[20] The International Covenant on Economic, Social, and Cultural Rights (ICESCR) requires states to provide health services that are "scientifically and medically appropriate and of good quality," utilizing scientifically proven, evidence-based treatment practices. This requirement applies "especially to the most vulnerable and marginalized sections of the population' including prisoners and detainees. UN Committee on Economic, Social and Cultural Rights, General Comment No. 14: the right to the highest attainable standard of health, November 8, 2000, para. 12(d). According to the United Nations Office for Drugs and Crime (UNODC), opioid users that are "likely to experience withdrawal complications require medically supervised withdrawal (detoxification)," the goal of which is "to achieve withdrawal in as safe and as comfortable a manner as possible." The UNODC and the United States National Institute on Drug Abuse (NIDA) of the National Institutes of Health recommend various medications shown to be effective in medically managed withdrawal from opioids including methadone, buprenorphine, and other non-opioid drugs. See US National Institute for Drug Abuse (NIDA), "Principles of Drug Addiction Treatment: A Research-Based Guide," NIH Publication No. 99-4180, October 1999, Revised April 2009, http://www.nida.nih.gov/PODAT/PODATindex.html (accessed August 3, 2011); UNODC, "Drug Abuse Treatment and Rehabilitation. A Practical Planning and Implementation Guide," 2002, http://www.unodc.org/unodc/en/treatment_toolkit.html (accessed August 3, 2011). For comprehensive discussion of human rights law in relation to treatment for opioid withdrawal and dependence, see Schleifer, R. and Bruce, R.D., "Ethical and human rights imperatives to assure medication-assisted treatment for opioid dependence in prisons and pre-trial detention," International Journal of Drug Policy 19:2008, 17-23 and "Report of the Special Rapporteur on the right of everyone to the enjoyment highest attainable standard of physical and mental health," UN DOC A/65/255 August 6, 2010.

THE NEED FOR HARM REDUCTION IN NORTH CAROLINA

North Carolina in Context

The South is at the heart of the HIV epidemic in the United States, with more people living with HIV and dying of AIDS than in any region in the country. The South has the highest rates of new infections, the most AIDS deaths, and the largest numbers of adults and adolescents living with HIV/AIDS.[21] In many states in the South,[22] socio-economic conditions combine with specific state laws and policies to undermine human rights and create an environment where the risk of acquiring, transmitting, and dying of HIV/AIDS is higher than anywhere else in the country.

Human Rights Watch has examined this environment of risk and identified policies in many southern states such as criminalization of HIV exposure, the failure to support HIV programs, abstinence-based sex education, prison policies, and lack of harm reduction programs that deny life-saving information and sponsor stigma and discrimination against those most vulnerable to HIV/AIDS.[23] These policies, along with disproportionately high rates of poverty, fuel the HIV epidemic in South and place North Carolina among the states most profoundly affected by HIV/AIDS.

HIV/AIDS

HIV is most commonly spread through engaging in unprotected sex and sharing injection equipment.[24] In North Carolina an estimated 35,000 people are living with HIV/AIDS.[25] The

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[21] CDC, HIV/AIDS Surveillance Report, 2007; for comprehensive discussions of disproportionate impact of HIV/AIDS on minorities in the South, see, Southern AIDS Coalition, "Southern States Manifesto: Update 2008, HIV/AIDS and Sexually Transmitted Diseases in the South, July 21, 2008; Sutton, M., et al, "A review of the Centers for Disease Control and Prevention's Response to the HIV/AIDS Crisis Among Blacks in the United States, 1981-2009," American Journal of Public Health, (2009) 99:No. S2, pp. 351-9; CDC, HIV/AIDS Epidemic and HIV/AIDS Prevention in the Hispanic/Latino Community: Consultation with Leaders from the Hispanic/Latino Community, April 2008.

[22] As used in this report, "the South" refers to the 17 states of Alabama, Arkansas, Delaware, District of Columbia, Florida, Georgia, Kentucky, Louisiana, Maryland, Mississippi, North Carolina, Oklahoma, South Carolina, Texas, Tennessee, Virginia and West Virginia, unless otherwise noted. This is the definition utilized by the majority of primary reference databases cited in this report including the US Centers for Disease Control , the US Census Bureau and the Kaiser Family Foundation HIV/AIDS database. These sources, in turn, are relied upon in secondary documents cited such as the National AIDS Strategy for the United States and the Southern AIDS Coalition Manifesto and Update.

[23] See Human Rights Watch, "Southern Exposure: Human Rights and HIV in the South," November 2010.

[24] Centers for Disease Control and Prevention, "Questions and Answers about HIV Transmission," March 25, 2010, http://www.cdc.gov/hiv/resources/qa/transmission.htm (accessed June 27, 2011).

[25] North Carolina Department of Health and Human Services (NCDHHS), Division of Public Health "North Carolina Epidemiologic Profile for HIV/STD Prevention and Care Planning," December 2010, http://www.epi.state.nc.us/epi/hiv/epiprofile1210/Epi_Profile_2010.pdf (accessed June 17, 2011), p.17.

rate of new HIV infections in the state is 41 percent higher than the national rate.[26] Nearly one in three people newly diagnosed with an HIV infection in North Carolina already have AIDS, the last stage of the disease, indicating that people are not seeking testing or care until they are very sick.[27] As a result of late testing and delayed treatment, the death rate from HIV disease in North Carolina is 10 percent higher than the national average.[28]

HIV/AIDS has a disproportionate impact on minority communities in North Carolina. The rate of HIV infection for non-Hispanic blacks in North Carolina is nine times greater than the rate among whites, and the rate for Hispanics is four times that of whites.[29] Two-thirds (66.5 percent) of all people diagnosed with AIDS in North Carolina are African-American.[30]

An estimated 50,000 injection drug users live in North Carolina.[31] Since the beginning of the epidemic in the early 1980s, more than one in five people with AIDS in North Carolina acquired the disease through injection drug use, one of the highest percentages in the country.[32] (See diagram below for a state comparison of cumulative AIDS diagnoses resulting from injection drug use from 1981 to 2009).

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[26] North Carolina Department of Health and Human Services (NCDHHS), Division of Public Health "North Carolina Epidemiologic Profile for HIV/STD Prevention and Care Planning," December 2009, http://www.epi.state.nc.us/epi/hiv/epiprofile1209/Epi_Profile_2009.pdf (accessed June 17, 2011), p.65. The overall rate of estimated new infections in North Carolina (32.2 per 100,000) is 41 percent higher than the overall national rate (22.8 per 100,000).

[27] NCDHHS, Division of Public Health, Epidemiology Section, Communicable Disease Branch, "State of North Carolina 2009 Statewide Coordinated Statement of Need/ Comprehensive Plan," February 2009, p. 11.

[28] Kaiser Family Foundation, State Health Facts, "Age-Adjusted Death Rate for HIV Disease, 2007," http://www.statehealthfacts.org/comparemaptable.jsp?ind=527&cat=11 (accessed July 18, 2011). The HIV death rate in North Carolina in 2007 was 4.1 per 100,000 per year, compared to 3.7 per 100,000 per year in the US.

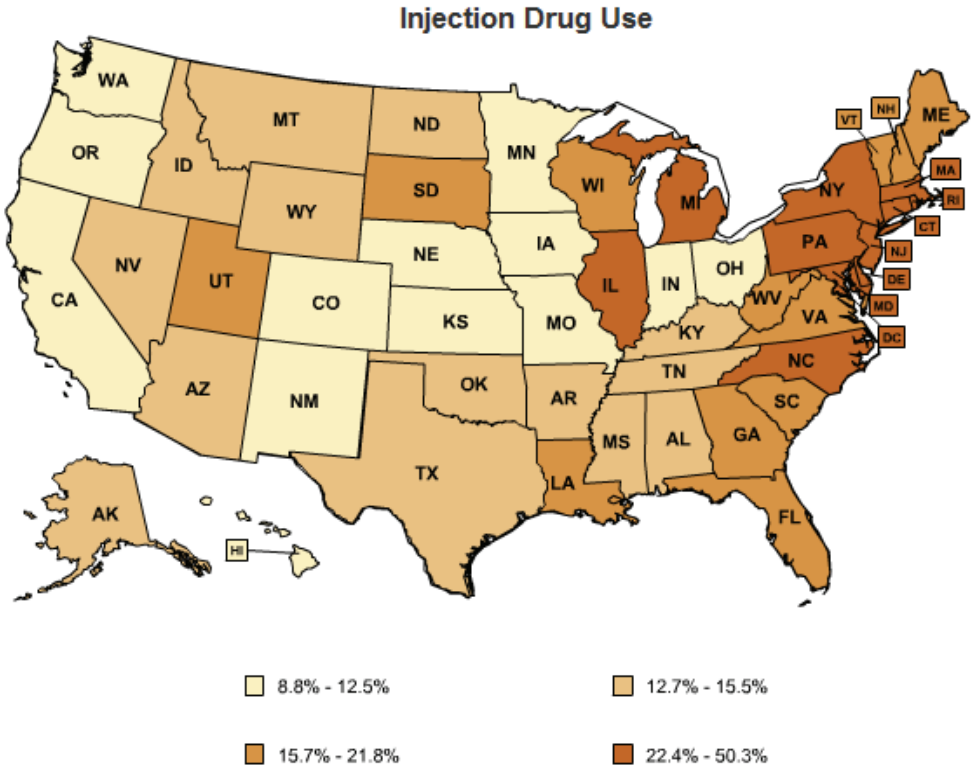
[29] NCDHHS, "NC Epidemiologic Profile," p. 17. The rate of new diagnoses of HIV infection was 69.7 per 100,000 for non-Hispanic blacks, 7.1 per 100,000 for non-Hispanic whites, and 28.8 per 100,000 for Hispanics.

[30] Centers for Disease Control and Prevention, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention, "North Carolina 2010 Profile," undated, http://www.cdc.gov/nchhstp/stateprofiles/pdf/North_Carolina_profile.pdf (accessed June 15, 2011).

[31] Friedman, S.F. et al. "Estimating Numbers of Injecting Drug Users in Metropolitan Areas for Structural Analyses of Community Vulnerability and for Assessing Relative Degrees of Service Provision for Injecting Drug Users," *Journal of Urban Health: Bulletin of the New York Academy of Medicine*, vol. 81, no. 3, 2004, p.377-400. Friedman et al. estimate that there are approximately 25,000 injection drug users in urban areas in North Carolina. The North Carolina Harm Reduction Coalition estimates there are an additional 25,000 injection drug users in rural and suburban areas in the state.

[32] Kaiser Family Foundation, State Health Facts, "50 State Comparisons: Estimated Numbers of AIDS Diagnoses Among Adults and Adolescents, by Transmission Category, Cumulative through 2009," http://www.statehealthfacts.org/comparetable.jsp?ind=845&cat=11 (accessed July 13, 2011). Data are from the beginning of the epidemic through 2009. Estimated numbers resulted from statistical adjustment that accounted for reporting delays, but not for incomplete reporting.

Estimated Numbers of AIDS Diagnoses Among Adults and Adolescents, by Transmission Category, Cumulative 1981 through 2009



Source: Kaiser Family Foundation, State Health Facts, 2009

New HIV infections resulting from injection drug use have declined in recent years. Notwithstanding, in North Carolina, four percent of all new HIV cases diagnosed in 2009 were attributed to injection drug use (including men who have sex with men who also inject drugs).[33]

Yet any new case of HIV resulting from injection drug use is preventable at little or no cost, and sterile syringe access can significantly reduce the risk of HIV transmission between injection drug users. Sterile syringe programs have proven for decades to reduce the risk of HIV transmission among injection drug users and contributed to the 80 percent drop in HIV transmission from injection drug use since the beginning of the epidemic in the United States.[34] A New York study showed that HIV prevalence fell from 54 to 13 percent among injection drug users after introduction of syringe distribution programs.[35]

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33 NC DHHS, "NC Epidemiologic Profile," p.26

34 Hall, H. Irene, Song, R., Rhodes, P. et al. "Estimation of HIV Incidence in the United States," *JAMA*, vol. 300, no.5, p. 526.

35 Jarlais D., et al. "Reductions in hepatitis C virus and HIV infections among injecting drug users in New York City, 1990-2001," *AIDS*, vol. 19, no. 3, 2005.

North Carolina law permits syringe purchase at pharmacies, but it is a class A misdemeanor to possess or distribute syringes or other paraphernalia that may be used for injection of illegal substances.[36] This means that people who use drugs and outreach workers face criminal sanctions for taking lifesaving measures to prevent HIV. In 2008 there were nearly 2,000 arrests for illegal possession of drug paraphernalia. Though not all of these involved syringes, a 2009 study found that fear of arrest was a likely factor in reducing purchase of syringes in pharmacies, particularly among African-Americans.[37]

Robert Childs, director of the North Carolina Harm Reduction Coalition (NCHRC), told Human Rights Watch that outreach workers depend on their relationship with local law enforcement to facilitate syringe access programs, and apprehension continues even when the relationship is positive. According to Childs, "In North Carolina, everyone involved in syringe exchange risks arrest."[38]

Viral Hepatitis

Hepatitis means inflammation of the liver. It is most often caused by one of several viruses that primarily attack the liver. The most common types of viral hepatitis in the US are hepatitis A, B, and C.[39] Hepatitis B and C are both transmitted through contact with the blood of an infected person, putting injection drug users at high risk of acquiring the disease.[40] Hepatitis B and C begin as acute infections, and can result in chronic disease and long-term liver damage when the virus remains in the body.[41]

An estimated one million US residents live with chronic hepatitis B infection, and 40,000 Americans are infected each year.[42] More than 40 percent of patients with acute hepatitis B must be hospitalized, and the virus is responsible for an estimated 3,000 deaths each year in the US.[43] The highest rates of hepatitis B occur in the South, and common risk factors

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[36] North Carolina General Statutes 90-113.22.

[37] Costenbader, et al, "Racial Difference in Acquisition of Syringes from Pharmacies Under Condition of Legal but Restricted Sales", International Journal of Drug Policy, doi;10.1016/j.drugpo.2009.12.006 (accessed October 22, 2010).

[38] Human Rights Watch telephone interview with Robert Childs, director of the North Carolina Harm Reduction Coalition, October 16, 2010.

[39] CDC, "Viral Hepatitis," July 28, 2011, http://www.cdc.gov/hepatitis/index.htm (accessed August 24, 2011).

[40] CDC, "Hepatitis B Information for Health Professionals," October 4, 2010, http://www.cdc.gov/hepatitis/HBV/index.htm (accessed August, 24, 2011).

[41] CDC, "Vital Hepatitis," http://www.cdc.gov/hepatitis/index.htm (accessed August 26, 2011).

[42] CDC, "Surveillance for Acute Viral Hepatitis --- United States, 2007," *Morbidity and Mortality Weekly Report: Surveillance Summaries*, vol. 53, no. SS03, May 22, 2009, http://www.cdc.gov/mmwr/preview/mmwrhtml/ss5803a1.htm (accessed June 8, 2011).

[43] Ibid.

include injection drug use and sexual transmission.[44] Harm reduction programs can reduce the risk of hepatitis B transmission by providing sterile injection equipment, condoms, testing, and referrals for treatment. The most effective way to prevent hepatitis B is through a vaccine, an intervention not available for Hepatitis C.[45]

Harm reduction services can reduce the risk of hepatitis C transmission by one-half.

Hepatitis C is the most common blood-borne infection in the US, affecting nearly 3.2 million people nationwide,[46] and can lead to serious health problems including cirrhosis (scarring of the liver) and cancer.[47] Preventing transmission is essential because there is no vaccine for the virus and treatment is difficult, costly, and not always effective.[48] Hepatitis C virus disproportionately affects injection drug users: 48 percent of people with acute hepatitis C infections in 2007 reported injection drug use.[49] One-third of HIV-infected injection drug users are also infected with hepatitis C virus.[50]

Harm reduction services, including access to sterile syringes and opioid substitution therapy, have been found to reduce risk of hepatitis C transmission among injection drug users by as much as **one-half**.[51] Prevention is extremely cost-effective. In the United States a sterile syringe costs $0.97, while the average lifetime cost of treatment for hepatitis C ranges from $100,000 to $300,000 for each person undergoing care.[52] With an estimated 150,000 cases of hepatitis C, North Carolina can expect to spend between $15 and $45 billion on treatment over the lifetimes of these patients.[53]

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[44] Ibid.

[45] CDC, "Viral Hepatitis and Injection Drug Users," September 2002, http://www.cdc.gov/idu/hepatitis/viral_hep_drug_use.htm (accessed August 24, 2011).

[46] CDC, "Surveillance for Acute Viral Hepatitis," *MMWR,* 2007.

[47] Sroczynski, G. et al. "Long-term effectiveness and cost-effectiveness of screening for hepatitis C virus infection," *European Journal of Public Health*, vol. 19, no. 3, 2009, pp. 245–253.

[48] Ibid.

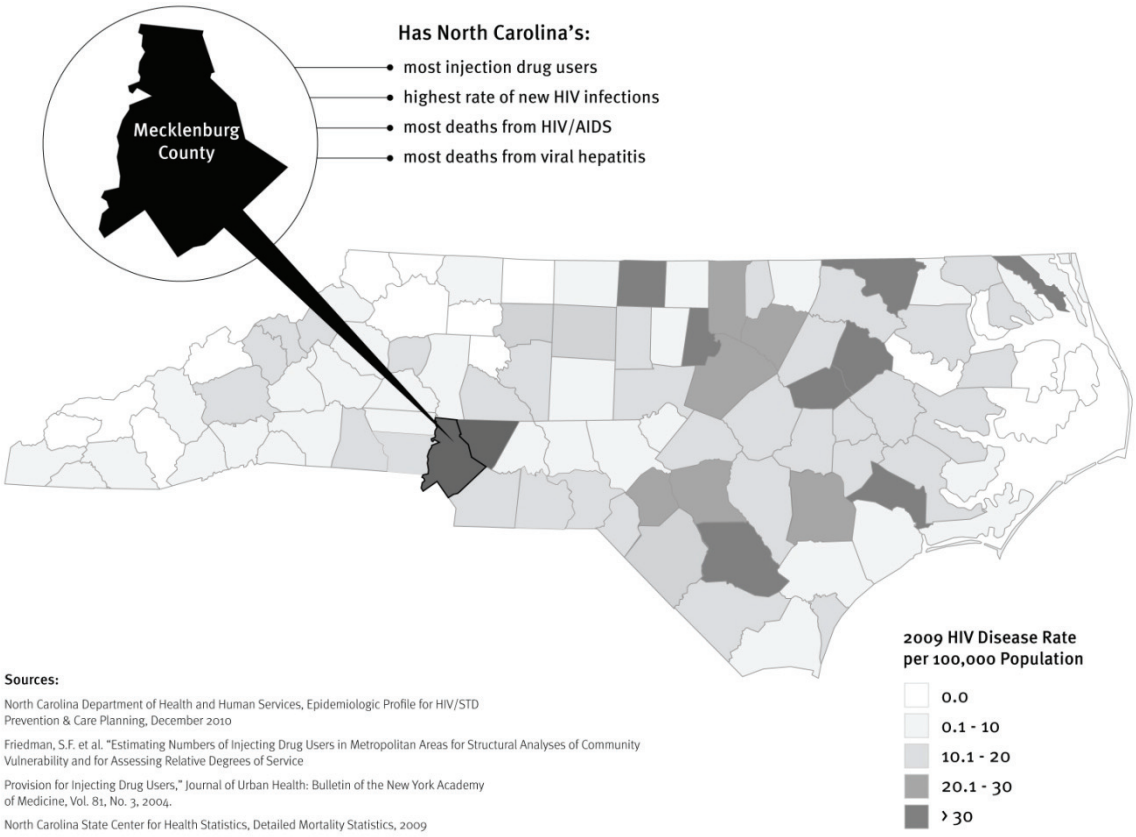
[49] US Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention, *2007 Disease Profile*, Atlanta: Centers for Disease Control and Prevention, 2009, p.24

[50] Ibid.

[51] Turner, K. et al. "The impact of needle and syringe provision and opiate substitution therapy on the incidence of hepatitis C virus in injecting drug users: pooling of UK evidence," *Addiction*, E-publication ahead of print, 2011.

[52] The C. Everett Koop Institute of Dartmouth Medical School, "Hepatitis C: Associated Health Costs - United States," 2011, http://www.epidemic.org/thefacts/theEpidemic/USHealthCareCosts/ (accessed July 22, 2011).

[53] Email communication from Susan Thompson, Hepatitis B/C coordinator, Communicable Disease Branch, North Carolina Division of Public Health, June 29, 2011.



A Harm Reduction Hotspot

Data from Mecklenburg County, in which the city of Charlotte is based, show an urgent need for harm reduction approaches to address the risk of HIV and hepatitis transmission among injection drug users. Mecklenburg County has an estimated 5,200 injection drug users, according to a 2004 study, although this number is probably higher today.[54] Mecklenburg County also has the state's highest rate of new HIV infections,[55] the highest number of deaths from HIV/AIDS,[56] and the highest number of deaths from viral hepatitis.[57] (See map above). Without expanded distribution of sterile syringes and other harm reduction programs, residents of Mecklenburg County will continue to die unnecessarily from preventable diseases.

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[54] Friedman, S.F. et al. "Estimating Numbers of Injecting Drug Users," *Journal of Urban Health*, p.385.

[55] NC DHHS, "NC Epidemiologic Profile," p.D-16

[56] North Carolina State Center for Health Statistics, Detailed Mortality Statistics, 2009, http://www.epi.state.nc.us/SCHS/data/dms/dmsnojs.cfm (accessed July 13, 2011).

[57] Ibid.

Inadequate Treatment

Many people in North Carolina cannot get treatment for drug dependence, and many health programs and services refuse to help people who use drugs. As a result, people who use drugs are denied access to help for other health problems, including HIV/AIDS and mental illnesses.

"There is a problem with the availability of drug treatment…. If you have no money or insurance, it is impossible to get help around here."[58]

—Jimmy, a 25-year-old drug user from Greensboro

While Medicaid in North Carolina covers some drug dependence treatment, eligibility is very limited. In North Carolina, non-elderly, non-disabled adults without children are categorically excluded from Medicaid coverage.[59] For working parents and their children to be eligible for Medicaid, annual family income must be no more than 49 percent of the federal poverty level,[60] or $8,971.90 for a family a three.[61] This leaves many people in North Carolina, where one in six residents live below the federal poverty level, without access to drug treatment.[62]

Many drug users face multiple, concurrent health problems, including drug dependence, mental illnesses, and HIV, but mental health facilities often refuse to accept drug dependent or uninsured patients.[63] By refusing to accept patients with limited resources or complicated diagnoses, many treatment facilities exclude those most in need of comprehensive, coordinated care. With restrictive Medicaid policies and treatment centers turning away the uninsured and patients with concurrent conditions, many North Carolinians are being denied access to affordable, evidence-based treatment.

Drug dependence treatment presents a window of opportunity for drug users with a high potential for relapse to learn about harm reduction practices in order to reduce the risks of

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[58] Human Rights Watch Interview with Jimmy L. (a pseudonym used to protect confidentiality), Greensboro, North Carolina, April 11, 2011.

[59] The Kaiser Commission on Medicaid and the Uninsured, *Medicaid, A Primer: Key Information on Our Nation's Health Coverage Program for Low-Income People*, June 2010, http://www.kff.org/medicaid/upload/7334-04.pdf (accessed July 16, 2011).

[60] Kaiser Family Foundation, State Health Facts, "Income Eligibility Limits for Working Adults at Application as a Percent of the Federal Poverty Level (FPL) by Scope of Benefit Package, January 2011," http://www.statehealthfacts.org/comparereport.jsp?rep=54&cat=4&sub=54&rgnhl=35 (accessed July 17, 2011).

[61] US Department of Health and Human Services, 2009 HHS Poverty Guidelines, February 2011, http://aspe.hhs.gov/poverty/09poverty.shtml (accessed July 23, 2011). The current federal poverty level for a family of 3 is $18,310.

[62] US Census Bureau, "North Carolina Quick Facts," June 23, 2011. http://quickfacts.census.gov/qfd/states/37000.html (accessed July 25, 2011).

[63] Ibid, p. 47

acquiring blood-borne and sexually transmitted infections. Yet research indicates many drug treatment facilities fail to educate drug users about the importance of sterile syringes and equipment.[64] Treatment facilities should integrate harm reduction principles and practices into drug dependence programs in order to provide comprehensive and effective health and prevention services to North Carolina residents.

Overdose

Drug overdose deaths in the US have increased five-fold since 1990, claiming the lives of 27,658 Americans in 2007, the last year for which figures are available.[65] After motor vehicle accidents, drug overdose is the second leading cause of injury death in the country.[66] In 2009 there were approximately 1,000 fatal drug overdoses in North Carolina, nearly one-half of them people under the age of 40.[67]

Harm reduction programs can help to prevent overdose fatalities by educating drug users about risk factors for overdose, signs of an overdose, and how to respond to save a victim. Many harm reduction programs also help drug users gain access to Naloxone, a medication that counters the effects of an opioid overdose. Harm reduction programs can dramatically reduce deaths from overdose by training drug users to resuscitate overdose victims and administer Naloxone.[69]

"I've seen Naloxone save people's lives—I've saved people's lives with it myself."[68]
—Linda, 35, drug user and harm reduction advocate

[64] SHARP, "North Carolina State Report," p. 47

[65] CDC. Web-based Injury Statistics Query and Reporting System (WISQARS). Available at http://www.cdc.gov/injury/wisqars/index.html (accessed July 14, 2011). See also CDC, "Drug Poisoning in the United States," July 2010, http://www.cdc.gov/HomeandRecreationalSafety/pdf/poision-issue-brief.pdf (accessed July, 25, 2011).

[66] Unintentional poisoning is the second leading cause of injury death after motor vehicle crashes, and 93 percent of unintentional poisoning deaths are caused by drug overdose. Centers for Disease Control and Prevention, "Drug Overdose Deaths – Florida, 2003-2009." *Morbidity and Mortality Weekly Report*, July 8, 2011, http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6026a1.htm?s_cid=mm6026a1_e&source=govdelivery (accessed July 12, 2011).

[67] North Carolina State Center for Health Statistics, Detailed Mortality Statistics, 2009, http://www.epi.state.nc.us/SCHS/data/dms/dmsnojs.cfm (accessed July 13, 2011).

[68] Human Rights Watch Interview with Linda V., Greensboro, North Carolina, April 11, 2011.

[69] Seal, K.H. "Naloxone distribution and cardiopulmonary resuscitation training for injection drug users to prevent heroin overdose death: a pilot intervention study," *Journal of Urban Health*, vol. 82, no. 2, 2005; See also New York City Department of Health and Mental Hygiene, "New Health Department Report Shows that Drug Overdose Deaths Have Declined," March 1, 2010, http://home2.nyc.gov/html/doh/html/pr2010/pr009-10.shtml (accessed July 1, 2011); Green, T.C. et al., "Distinguishing signs of opioid overdose and indication for Naloxone: an evaluation of six overdose training and Naloxone distribution programs in the United States," *Addiction,* vol. 103, no. 6, 2008, p.979-989; Maxwell, S. et al., "Prescribing Naloxone to actively injecting heroin users: a program to reduce heroin overdose deaths," *Journal of Addictive Diseases,* vol. 25 no. 3, 2006, p.89-96.

OVERDOSE PREVENTION IN NORTH CAROLINA: PROJECT LAZARUS

> *"The voices and experiences of people who use drugs and people with histories of addiction must be part of any dialogue on drug policy."*[70]
> —Daniel Raymond, policy director of the Harm Reduction Coalition

Project Lazarus is a community-based overdose prevention project that was formed to address the alarmingly high rate of unintentional drug overdose death in Wilkes County, North Carolina.

Several historical and cultural factors contributed to the high number of overdose fatalities in the area, located in the foothills of the Appalachians. A history of home-made liquor manufacturing or "moonshine" activity during the prohibition era cultivated a tradition of substance use at the margins of the law. The primary industries in Wilkes County include logging, textiles, manufacturing, and chicken and cattle farming. The physical demands of employment in these industries lead to occupational injuries and chronic pain, causing many county residents to rely on prescription opioids for pain management. Poverty, unemployment, and limited educational opportunities created "a cycle of socioeconomic depression."[71] As a result, the Wilkes County overdose death rate was consistently and significantly higher than the statewide average, indicating an urgent need for a public health response.[72]

Project Lazarus helps drug users in Wilkes County and western North Carolina gain access to Naloxone, an overdose rescue medication that can counteract an opioid overdose. It also provides education and training on preventing and responding to drug overdose, pain management referrals, tips on safe storage and disposal of medications, referrals to drug treatment programs, and a 24/7 call line to provide information and support to drug users. The project partners with medical providers, law enforcement, and public health officials to increase awareness of the needs of drug users and ensure a coordinated community response to the issue of drug overdose.

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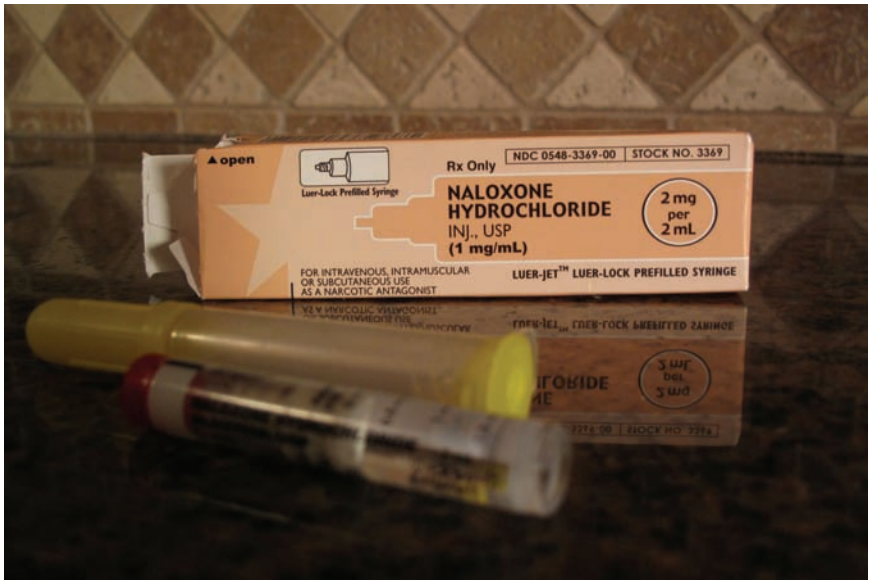
[70] Testimony of Daniel Raymond, Joint Hearing of the Committee on Mental Health, Mental Retardation, Alcoholism, Drug Abuse and Disability Services and the Subcommittee on Drug Abuse, February 24, 2009, http://harmreduction.org/section.php?id=54 (accessed July 18, 2011).

[71] Albert, S. et al., "Project Lazarus: community-based overdose prevention in rural North Carolina," *Pain Medicine* vol. 12, 2011, p. S77–S85.

[72] Ibid. In 2009, Wilkes County's unintentional poisoning mortality rate, primarily from drug overdose, was four times the statewide average in 2009 (46.6 per 100,000 population per year compared to the NC statewide rate of 11.0 per 100,000 population per year). North Carolina State Center for Health Statistics, " Substances Identified From T-codes Involved in Poisoning Deaths of Unintentional or Undetermined Intent North Carolina Residents: 2000–2009," Raleigh, NC: NC Department of Health and Human Services, State Center for Health Statistics, 2010.

Project Lazarus' efforts have helped to reduce overdose rates in Wilkes County by 42 percent, and emergency room admissions for overdose have dropped by 15 percent.[73]



Naloxone, a medication that can counteract an opioid overdose. ©2011 Project Lazarus

Though Wilkes County is in some ways unique, Project Lazarus' response to the overdose crisis can be usefully and effectively replicated elsewhere. Indeed, in 2008, the North Carolina Medical Board issued a policy statement encouraging doctors to follow the project's approach to prevent drug overdose.[74] North Carolina public health officials plan to implement the Project Lazarus plan statewide. [75]

The high cost of emergency care for overdose makes prevention highly cost effective. Inpatient hospitalizations alone for opioid poisoning in North Carolina cost more than $20 million per year. For *each* overdose prevented through Project Lazarus, there is a $20,000 to $30,000 savings in medical expenses and lost productivity.[76]

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[73] Albert, S. et al., "Project Lazarus: community-based overdose prevention ," 2011; Community Care of North Carolina (CCNC), "CCNC Launches Chronic Pain Initiative," 2011, http://newsletter.communitycarenc.org/?p=188 (accessed August 25, 2011).

[74] North Carolina Medical Board, "Position Statement: Drug Overdose Prevention," September 1, 2008, http://www.ncmedboard.org/position_statements/detail/drug_overdose_prevention/ (accessed July 16, 2011). "The prevention of drug overdoses is consistent with the Board's statutory mission to protect the people of North Carolina. The Board therefore encourages its licensees to cooperate with programs like Project Lazarus in their efforts to make Naloxone available to persons at risk of suffering opioid drug overdose."

[75] Community Care of North Carolina (CCNC), "CCNC Launches Chronic Pain Initiative," 2011, http://newsletter.communitycarenc.org/?p=188 (accessed August 25, 2011).

[76] Project Lazarus, "Policy Briefing Document Prepared for the North Carolina Medical Board in advance of Public Hearing Regarding Prescription Naloxone" November 2007, http://www.harmreduction.org/downloads/North%20Carolina%20Naloxone%2007.pdf (accessed July 17, 2011).

STAN'S STORY

Stan, a 62-year-old African-American man, was addicted to heroin for decades. At 47 he stopped using drugs, and started working as a volunteer with an HIV/AIDS organization. As a volunteer Stan distributed condoms and brochures, but realized these efforts were not enough to stop the spread of blood-borne diseases. Stan began safely disposing of contaminated syringes he found in parking lots and playgrounds, and in 2005 launched the Twin Cities Harm Reduction Initiative.

"Denying access to materials that can save lives is criminal."

Working by himself, seven days a week, Stan visits areas where drug use is common: "shooting galleries" (places where illegal drugs may be obtained, prepared, and taken by injection, often with equipment provided on the premises), crack houses, and street corners.

He knows too well the profound health consequences for those who struggle to find clean injection equipment. Stan has been HIV-positive for 25 years, and also has hepatitis C. Stan's wife has HIV, and is experiencing serious health complications from the disease. "Denying access to materials that can save lives is criminal," he said. "I lost my cousins, my sister-in-law, and my first wife to AIDS because of contaminated syringes," Stan told Human Rights Watch, "Drug users have just been forgotten."[77]

"I don't preach to anybody about what they should or shouldn't be doing."

Beginning work at 5:00 a.m., Stan delivers HIV testing and education, condoms, wound care kits, and other harm reduction materials to three counties. North Carolina's drug paraphernalia laws, however, prohibit distributing syringes.[78] "You can purchase them at a pharmacy," Stan explained, "but the pharmacist has discretion, so as a practical matter, injection drug users have trouble finding clean syringes."[79]

In the evenings Stan visits crack houses and other places where people are using drugs to deliver alcohol, bleach, and other materials that help drug users sterilize their equipment.

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77 Human Rights Watch Interview with Stan D. (pseudonym used to protect confidentiality), Greensboro, North Carolina, April 11, 2011.

78 North Carolina General Statutes - Chapter 90 Article 5B, North Carolina Drug Paraphernalia Act." (1981, c. 500, s. 1.)

79 North Carolina Administrative Code, Title 21, Occupational Licensing Boards and Commissions: Pharmacy, Section 1800-Prescriptions, 21 NCAC 46.1801, "Right to refuse a prescription," 2007, Pharmacy regulations stipulate that pharmacists should use their professional judgment in deciding to whom to sell syringes.

He also distributes a "safe smoke kit" with rubber mouthpieces to decrease hepatitis transmission, as well as ascorbic acid to replace the vitamin C that crack drains from the body.

Outreach worker giving out rubber tips for crack pipes to prevent hepatitis C transmission. © 2011 Hadley Gustafson

As a former drug user, Stan knows how to reach the people who need the services he offers. "I know not to bother people when they are sick or on a mission to get drugs," he said. Stan is committed to a non-judgmental approach. "I don't preach to anybody about what they should or shouldn't be doing."[80]

Stan does not limit his outreach to drug users. For commercial sex workers, Stan distributes a kit with male and female condoms, lubricant, domestic violence resources, and a pamphlet about human rights. "I tell them that they have the right to say no just like anybody else," he explained.[81]

Without restrictive drug paraphernalia laws, Stan says he would broaden the scope of his harm reduction program. "I would set up shop on the corner. I would do this work in the open," he says. "I could reach many more people who really need it. And people would be able to have a [clean] needle on them when they needed it."[82]

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[80] Human Rights Watch Interview with Stan D. , Greensboro, North Carolina, April 11, 2011.

[81] Ibid.

[82] Ibid.

HARM REDUCTION AND HUMAN RIGHTS

> *"Too often, drug users suffer discrimination, are forced to accept treatment, marginalized, and often harmed by approaches which over-emphasize criminalization and punishment while under-emphasizing harm reduction and respect for human rights. This is despite the longstanding evidence that a harm reduction approach is the most effective way of protecting rights, limiting personal suffering, and reducing the incidence of HIV."*
>
> —Navanethem Pillay, UN High Commissioner for Human Rights, March 10, 2009[83]

All persons have the right to adequate means to protect their health and well being, and governments must protect these rights without discrimination. These fundamental principles are enshrined in the Universal Declaration of Human Rights.[84] Other international instruments address the meaning and scope of the right to health, and international bodies have specifically recognized harm reduction practices as a vital element of the right to maintain one's health and prevent disease. Under international human rights law, everyone has the right to appropriate health care, including drug users and people living with HIV/AIDS and hepatitis.[85] Under other international instruments, the US is also obligated to address racial disparities in the public health and to ensure that minority communities have equal access to HIV prevention, care, and treatment. [86]

Condoms and sterile syringes, when used correctly and consistently, reduce rates of HIV, hepatitis, and other blood-borne infections.[87] Opioid-substitution therapy such as methadone or buprenorphine reduces illicit opioid use, reduces overdose deaths, and helps drug users prevent HIV and hepatitis C. Opioid-substitution therapy also helps

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[83] United Nations Office of the High Commissioner for Human Rights (UN OHCHR), "High Commissioner calls for focus on human rights and harm reduction in international drug policy," UN OHCHR Press Release, March 10, 2009, http://www.unhchr.ch/huricane/huricane.nsf/view01/3A5B668A4EE1BBC2C12575750055262E?opendocument (accessed June 6, 2011).

[84] Universal Declaration of Human Rights, UNGA Res. 217 (111) UN GAOR, 3d Session, Supp. No. 13, UN Doc. A/810 (1948) article 25.

[85] ICESCR, articles 2, 12. See also General comment No. 14, The Right to the Highest Attainable Standard of Health, Committee on Economic, Social and Cultural Rights, 22nd Session, 2000.

[86] International Convention on the elimination of all forms of Racial Discrimination, adopted December 21, 1965, G.A. Res. 2106 (XX), annex, 20 UN GAOR Supp. (Npo. 14) at 47, UN Doc A/6014 (1966), 660 UNTS 195, entered into force January 4, 1969, ratified by the United States on November 20, 1994, article 5.

[87] Holmes, K., Levine, R., & Weaver, M., "Effectiveness of condoms in preventing sexually transmitted infections," *Bulletin of the World Health Organization*, vol. 84 issue 6, 2004; World Health Organization (WHO), "Evidence for action technical papers: Effectiveness of sterile needle and syringe programming in reducing HIV/AIDS," Geneva: World Health Organization, 2004.

people living with HIV take their HIV medications on a regular basis, a key factor in managing this chronic disease.[88] Both needle and syringe exchange programs and opioid substitution therapy are essential components of the comprehensive HIV prevention, treatment, and care package for people who inject drugs, as defined by the World Health Organization, United Nations Office on Drugs and Crime, and Joint United Nations Programme on HIV/AIDS.[89]

Drug dependence is a medical condition that can be a disability, and as such it is protected by both the right to health and the right to live free from discrimination.[90] International human rights law prohibits "discrimination of any kind on the basis of disability," and requires states to take action to prevent the "discriminatory denial of health care or health services…on the basis of disability."[91] Persons with disabilities should have access to medical and social services that allow them to achieve optimal independence and functioning. Drug dependence is a medical condition, and denying drug users care or treatment constitutes punishment and discrimination.

The right to health also requires that nations refrain from acts that would harm or interfere with the protection of health. Laws and policies that "are likely to result in bodily harm, unnecessary morbidity and preventable mortality" are considered violations of the right to the highest attainable standard of health.[92] State policies that criminalize syringe possession and force harm reduction programs to operate underground deny individuals the right to disease prevention and medical treatment.

In the National HIV/AIDS Strategy for the US, access to sterile syringes is endorsed as one of several "scientifically proven…approaches that reduce the probability of HIV transmission."[93] The federal ban on funding for syringe exchange programs was lifted in

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88 WHO, "Substitution maintenance therapy in the management of opioid dependence and HIV/AIDS prevention," Position Paper, 2004, p.13.

89 World Health Organization, United Nations Office on Drugs and Crime, and Joint United Nations Programme on HIV/AIDS, *WHO, UNODC, UNAIDS Technical Guide for countries to set targets for universal access to HIV prevention, treatment and care for injecting drug users,* Geneva: World Health Organization, 2009, p. 6. Available at http://extranet.who.int/iris/bitstream/123456789/657/2/9789241597760_eng.pdf.

90 UN Committee on Economic, Social and Cultural Rights (CESCR)," General Comment No. 5: Persons with Disabilities," December 9, 1994, E/1995/22; International Covenant on Civil and Political Rights (ICCPR), adopted December 16, 1966, G.A.Res. 2200A (XXI), 21 U.N. GAOR Supp. (No. 16) at 52, U.N. Doc. A/6316 (1966), 999 U.N.T.S. 171, entered into force March 23, 1976, art. 26; Convention on the Rights of Persons with Disabilities (CRPD), adopted December 13, 2006, G.A. Res. 61/106, Annex I, U.N. GAOR, 61st Sess., Supp. (No. 49) at 65, U.N. Doc. A/61/49 (2006), entered into force May 3, 2008, art. 5, signed by the United States July 30, 2009.

91 Convention on the Rights of Persons with Disabilities (CRPD), art. 25

92 ICESCR, "General Comment No. 14," para. 50.

93 Office of National AIDS Policy, "National HIV/AIDS Strategy for the United States," July 2010, p. 16, http://www.whitehouse.gov/sites/default/files/uploads/NHAS.pdf (accessed June 2, 2011).

2009 in the US,[94] yet local laws prevent many states from expanding syringe access.[95] State and local laws that restrict access to harm reduction services undermine both public health and human rights.

The US has signed the International Covenant on Economic, Social and Cultural Rights, the key international treaty that protects the right to health, and is bound not to act in ways that undermine its purpose and effect. That treaty has been interpreted to require that governments ensure, at a minimum, a range of harm reduction interventions including syringe programs, opioid substitution therapy, overdose prevention, and harm reduction services for youth, prisoners and other vulnerable groups.[96]

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[94] Department of Health and Human Services, "Implementation Guidance for Syringe Services Programs," July 2010, http://www.cdc.gov/hiv/resources/guidelines/PDF/SSP-guidanceacc.pdf (accessed July 20, 2011).

[95] For analysis of the legality of SEPs in all 50 states, see "Project on Harm Reduction in the Health Care System," Temple University School of Law, http://www.temple.edu/lawschool/aidspolicy/, accessed July 22, 2011. Human Rights Watch has addressed the barriers to access to sterile syringes in the southern US, see Human Rights Watch, "Southern Exposure: Human Rights and HIV in the Southern United States," November 2010.

[96] The UN Committee on Economic, Social and Cultural Rights has interpreted the article 12 of the Covenant on Economic, Social and Cultural Rights to require, at a minimum, that states ensure a range of harm reduction interventions, including needle and syringe programs; opioid substitution therapy; overdose prevention; youth focused harm reduction services; and prison harm reduction. See Committee on Economic, Social, and Cultural Rights (CESCR) concluding observations for Russia (2011), para 29; Tajikistan (2006); UN Doc No E/C.12/TJK/CO/1 para 70. Ukraine (2007), UN Doc No E/C.12/UKR/CO/5 paras 28 and 51.; Poland (2009); Kazakhstan (2010); Mauritius (2010). While not binding on the U.S., which has yet to ratify the ICESCR, this interpretation should be taken as an important interpretive guidance to the general human rights obligation to ensure adequate medical care and social services to protect health.

CRIMINALIZING PREVENTION: CONDOMS AS EVIDENCE OF PROSTITUTION

Candace, a sex worker in Durham, runs her sex trade from a boarded-up building in a rough neighborhood. When the North Carolina Harm Reduction Coalition visited her, Candace took a few condoms but hesitated to take more. She told Human Rights Watch that in Durham the police can use possession of condoms to bolster a prostitution charge.

> *"I'd like to take more [condoms], but the police* ***charge you*** *if you're carrying too many."*[97]
> —Candace, a sex worker in Durham, North Carolina

A recent study by researchers at the United States Centers for Disease Control and Prevention found that the perception among North Carolina sex workers that they will be charged with solicitation for carrying condoms is widespread and appears to be contributing to reduced condom use.[98] Durham police have not responded to inquiries by Human Rights Watch regarding the use of condoms as evidence of prostitution, although the Durham public defender's office told Human Rights Watch that it has not observed police engaging in this practice.[99] Similar practices, however, have been documented in Miami,[100] Washington DC, [101] and other cities.[102] In order to ensure that sex workers and clients have ready access to disease prevention, state and local governments should dispel any association between carrying condoms and receiving criminal penalties, particularly among sex workers and other populations who may fear arrest.

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[97] Human Rights Watch Interview with Candace J. (pseudonym used to protect confidentiality), Durham, North Carolina, April 14, 2011.

[98] Kroeger, K. et al. "Rapid Assessment of the STD/HIV Prevention Needs of Sex Workers and Clients in North Carolina," Atlanta: Division of STD Prevention, Centers for Disease Control and Prevention, November 2010.

[99] Human Rights Watch telephone interview with Thomas Maher, director of Indigent Legal Services, Durham, North Carolina, August 15, 2011.

[100] Email communication from Marissa Altman, assistant public defender, Office of Miami Dade Public Defender to Human Rights Watch, August 18, 2011.

[101] See e.g. Alliance for a Safe & Diverse DC, "Move Along: Policing Sex Work in Washington, D.C." Washington, D.C.: Different Avenues, 2008.

[102] See e.g. Berenstein, N.,"Condoms = Arrest? Police policies often discourage sex workers from carrying protection," *Ms. Magazine*, Winter 2010.

THE NORTH CAROLINA HARM REDUCTION COALITION

> *"I try to avoid activities that put me at risk, but a lot of guys here don't know much about HIV, for example, and how you can get it. Harm reduction programs are helpful to educate people so they won't get infected."*[103]
>
> —Fermin, a migrant worker from Guatemala

The North Carolina Harm Reduction Coalition is the state's only comprehensive harm reduction program. NCHRC engages in grassroots advocacy, resource development, coalition building, and direct services for law enforcement and those made vulnerable by drug use, sex work, overdose, immigration status, gender, sexually transmitted infections, HIV, and hepatitis.

NCHRC's activities include:

- Advocacy for syringe decriminalization, legalization of syringe exchange programs, sex worker rights, immigrant health services, and improved overdose prevention laws;
- Street-based harm reduction outreach and medical services;
- Outreach and support for transgender people who often use syringes for hormone injections;
- Harm reduction resource development;
- Safer sex work programming;
- Education and support for migrant farmworkers who use syringes to inject vitamins and steroids for strength, and pain relievers for pain management;
- Support groups for active drug users and people living with hepatitis C;
- Overdose prevention programming;
- HIV and hepatitis C counseling, rapid testing, and referral services;
- Referrals for the safe disposal of biohazards related to drug use;
- Referrals for drug treatment, health services, mental health services, sexual assault support agencies, domestic violence support services, and HIV/AIDS services;
- Safer sex education.

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[103] North Carolina Harm Reduction Coalition, "Harm Reduction and Migrant Labor: An Interview with Fermin, A North Carolina Day Laborer," May 27, 2011.

NCHRC Impact

- Conducted advocacy that led to the introduction of House Bill 601 to decriminalize syringe access and bipartisan support for syringe decriminalization;
- Co-organized North Carolina HIV/AIDS Advocacy Day at the state capitol attended by hundreds of citizens and advocates statewide in both 2010 and 2011 to advocate for syringe decriminalization and syringe exchange;
- Collected over a thousand petition signatures to legalize syringe exchange in North Carolina;
- Reached 3,485 individuals through 58 street-based harm reduction outreach events in 2010;
- Administered 102 HIV tests with North Carolina sex workers and drug users in 2010;
- Conducted 39 trainings and seminars on overdose and hepatitis C prevention in 2010, reaching 1,456 people;
- Hosted 77 trainings on the benefits of Syringe Exchange in 2010, reaching 2,363 people;
- Participated in 182 coalition advocacy events/meetings and 32 meetings with North Carolina Representatives in 2010; as of July 2011 NCHRC met with 67 legislators;
- Established the support of law enforcement for harm reduction activities.

HARM REDUCTION, PUBLIC SAFETY, AND LAW ENFORCEMENT[104]

"Syringe exchange programs take dirty needles off the streets and increase the safety of our police officers. [105]
—Bob Scott, former captain with the Macon County Sheriff's Office

Harm reduction programs can increase public safety and protect law enforcement officials by reducing accidental needle stick injuries on the street and in prisons. One study found that 30 percent of police officers in an urban police force had experienced a needle stick injury on the job, and 27 percent had experienced two or more such injuries.[106] These often occur when law enforcement officials conduct searches and drug users have concealed injection equipment. When drug users are legally permitted to carry safe injection equipment, there is less incentive to conceal needles and syringes during a search on the street or in a prison setting. In Connecticut, the decriminalization of syringe possession led to a 66 percent reduction in needle stick injuries in the local police force.[107] Similar reductions in needle stick injuries have been observed among prison staff in several countries and have led to acceptance of harm reduction programs by corrections and other law enforcement officers.[108]

Many harm reduction programs include safe disposal of contaminated syringes, and encourage drug users to trade in used syringes for clean equipment. As a result, these programs reduce the number of contaminated syringes circulating a community, protecting drug users, law enforcement, and the public.[109]

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[104] See e.g. Foundation for AIDS Research (amfAR), "Public Safety, Law Enforcement, and Syringe Exchange," May 2011, http://www.amfar.org/uploadedFiles/In_the_Community/Publications/factsheetJan2010.pdf (accessed August 25, 2011). See also "The Bratton Declaration," Memorandum from William J. Bratton, Los Angeles Chief of Police, to All Los Angeles Police Department Employees, July 8, 2005, where Bratton instructs Los Angeles Police Officers to cease arrest, detention, or investigation of individuals participating in city-sponsored syringe exchange programs.

[105] North Carolina Harm Reduction Coalition, "Police Voices," March 8, 2011, http://www.nchrc.net/NCHRC/Police_Voices.html (accessed August, 25, 2011).

[106] Lorentz, J., Hill, J. & Samini, B. "Occupational needle stick injuries in a metropolitan police force," *American Journal of Preventive Medicine*, vol. 18, 2000, p. 146–150. See also Foundation for AIDS Research (amFAR), "Fact Sheet: Public Safety, Law Enforcement, and Syringe Exchange," May 2011, http://www.amfar.org/uploadedFiles/In_the_Community/Publications/fact%20sheet%20Syringe%20Exchange%2011.pdf?n=9491 (accessed July 2, 2011).

[107] Groseclose, S.L. et al., "Impact of increased legal access to needles and syringes on practices of injecting-drug users and police officers—Connecticut, 1992-1993," *Journal of Acquired Immune Deficiency Syndromes & Human Retrovirology*, vol. 10. no. 1, 1995, p. 82–89.

[108] World Health Organization, *Evidence for action technical papers: Interventions to Address HIV/AIDS in prisons: Needle and syringe programmes and decontamination strategies*, Geneva: World Health Organization, 2007, p. 14.

[109] See e.g. Doherty MC, Junge B, Rathouz P, Garfein RS, Riley E, Vlahov D. "The effect of a needle exchange program on numbers of discarded needles: A 2-year follow-up," *American Journal of Public Health*, vol. 90, no. 6, 2000, p. 936–939.

Opponents of harm reduction often express concern that harm reduction programs condone or encourage drug use, but there is no evidence that increased access to sterile syringes increases drug use or drug-related crime in a community. [110] Indeed, harm reduction programs often provide an essential link for drug users to drug treatment and health services. In Seattle, for example, participants in a syringe exchange program were five times more likely to enter drug treatment than non-participants.[111]

With growing evidence of the benefits, some North Carolina law enforcement officials are speaking out in of support of harm reduction.[112] Corporal D.A. Jackson, who served in law enforcement for over 26 years, 18 in the Guilford County Sheriff's Department, is one of them. She said:

"One of the main components of a law enforcement officer's job is to conduct searches. We search people, homes, vehicles, and storage compartments; we stick our hands in places most people wouldn't think to touch, and in every search we are at risk for needle-sticks and contracting infectious diseases. I support harm reduction programs because I'll advocate for anything that protects my life and the lives of my fellow officers."[113]

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[110] Institute of Medicine, "Preventing HIV Infection Among Injecting Drug Users in High-Risk Countries: An Assessment of the Evidence," Washington, D.C.: National Academies Press, 2006; Marx MA, et al., "Trends in crime and the introduction of a needle exchange

program," *American Journal of Public Health*, vol. 90, no. 12, 2000, p. 1933–6.

[111] Hagan H, McGough JP, Thiede H, Hopkins S, Duchin J, Alexander ER., "Reduced injection frequency and increased entry and retention in drug treatment associated with needle-exchange participation in Seattle drug injectors," *Journal of Substance Abuse Treatment*, vol. 19, 2000, p. 247–252.

[112] See "The Bratton Declaration," Memorandum from William J. Bratton, Los Angeles Chief of Police, to All Los Angeles Police Department Employees, July 8, 2005, where Bratton instructs Los Angeles Police Officers to cease arrest, detention, or investigation of individuals participating in city-sponsored syringe exchange programs.

[113] North Carolina Harm Reduction Coalition, "Police Voices," May 23, 2011, http://www.nchrc.net/NCHRC/Police_Voices.html (accessed August 25, 2011).

HOW TO EXPAND HARM REDUCTION IN NORTH CAROLINA

A North Carolina resident signs the petition to amend North Carolina's drug paraphernalia law to decriminalize syringe possession. © 2011 Hadley Gustafson

Misguided laws and policies are preventing expansion of essential services. The North Carolina Harm Reduction Coalition, Stan, Linda, and many others are working hard to advance harm reduction, but as long as state laws criminalize syringe possession, injection drug users will be denied access to a proven method of HIV and hepatitis prevention. Project Lazarus's work has made Naloxone more available from doctors, but this life-saving drug should be distributed widely through trained peer counselors who can reach those who are most vulnerable to overdose. With the support of state government for harm reduction, many more people could be reached and many more saved.

Recommendations to Ensure Access to Harm Reduction in North Carolina

To the United States Government:

- Fully review and identify state laws and policies that are blocking implementation of harm reduction at the state level.
- Provide guidance, incentives and model drug control laws to ensure that state law and policy is consistent with public health objectives and the goals of the National AIDS Strategy.

To the Government of North Carolina:

- Legalize the possession and distribution of sterile syringes. Enact House Bill 601 to amend drug paraphernalia laws to protect providers and users of sterile syringes from arrest or prosecution for drug possession.
- Enact a 911 "Good Samaritan" or "Medical Amnesty" law to protect those who seek help for an overdose victim from arrest for drug offenses.
- Ensure that police and prosecutors do not use condoms as evidence of prostitution.
- Ensure access to affordable drug treatment that includes opioid substitution therapy and provides harm reduction education and information.

To City and County Governments in North Carolina:

- Work with state health officials and harm reduction experts, including the North Carolina Harm Reduction Coalition, to implement and support syringe access programs. Ensure that safe disposal of used syringes and police protocols for safely handling syringes are part of these programs.
- Work with police departments to ensure that individuals are not arrested, harassed, searched, detained or otherwise punished based on their possession of syringes or condoms.

To State Public Health Officials:

- Promote harm reduction education and information throughout the state.
- Promote syringe decriminalization and apply for federal funding to support syringe distribution programs.
- Work with harm reduction experts including Project Lazarus and others to promote increased access to Naloxone to prevent overdose among drug users by authorizing and supporting its distribution through trained peer counselors and other outreach workers.

To Police Departments in North Carolina:

- Cease all arrest, harassment, search, detention, and other punitive action against individuals for possessing sterile or used syringes or condoms. Take steps to ensure that the communities are informed that punitive action will not be taken for activities related to disease prevention. Refrain from arresting people for possession of controlled substances based on trace amounts of narcotic drugs contained in a used syringe.
- Instruct all officers patrolling relevant neighborhoods that participation in a sterile syringe program is a permissible activity.
- Establish a "safe zone" through which individuals may freely enter and leave legal syringe exchange sites. Regularly update police officers about safe zones, and work with syringe exchange providers to ensure continued respect for their existence and purpose.
- Work with syringe exchange and other harm reduction service providers to develop training protocols for all narcotics, vice, and street officers on the basic principles of sterile syringe programs. Provide regular refresher training, as well as mandatory training for new officers. Regularly update the protocol to reflect the emergence of new harm reduction services in the community.
- Develop and implement a protocol for the safe handling of syringes found in the course of investigative searches. Monitor the implementation of the foregoing recommendations by ensuring that police officers who do not comply with them are appropriately disciplined.

HARM REDUCTION RESOURCES

Drug Policy Alliance
http://www.drugpolicy.org

Harm Reduction Coalition
http://www.harmreduction.org/

Harm Reduction International
http://www.ihra.net/

North Carolina Harm Reduction Coalition
http://www.nchrc.net/NCHRC/Home.html

Project Lazarus
http://www.projectlazarus.org/

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HUMAN RIGHTS WATCH

We Know What to Do

Harm Reduction and Human Rights in North Carolina

Harm reduction is a way of preventing disease and promoting health that "meets people where they are" rather than making judgments about where they should be in terms of their personal health and lifestyle. Accepting that not everyone is ready or able to stop risky or illegal behavior, harm reduction focuses on promoting scientifically proven ways of mitigating health risks associated with drug use and other high risk behaviors, including condom distribution, access to sterile syringes, medications for opioid dependence such as methadone and buprenorphine, and overdose prevention.

Emphasizing public health and human rights, harm reduction programs provide essential health information and services while respecting individual dignity and autonomy. Implementing harm reduction practices widely in the US is not just sound public health policy, it is a human rights imperative.

Yet in too many states, misguided laws and policies block harm reduction and prevent drug users from accessing sterile syringes that can save their lives. One such state is North Carolina.

With the support of state government for harm reduction, many more people could be reached and many more saved.

An overdose rescue kit containing sterile syringes and Naloxone, a medication used to counteract an opioid overdose.