HARM REDUCTION INTERNATIONAL

Injecting Drug Use Among Children and the Child's Right to Health

Submission of Harm Reduction International to the OHCHR Study on Children's Right to Health (Human Rights Council Resolution 19/37)

Yana was just eight years old when she started living on the streets. Her father, an alcoholic, died young and she was separated from her mother who was sent to jail. Originally from Moldova, one of the poorest countries in Europe, Yana wandered through several towns and eventually ended up on the streets of Odessa, Ukraine. Her 'home' was a makeshift shed in a park. A group of 20 street children built the hideout themselves, the youngest only six years old. They begged, stole and prostituted themselves to survive. Drugs helped them cope with their lives. Through sharing needles they also shared HIV. Yana fell sick and died at the age of thirteen on the streets of Odessa, addicted to drugs and infected with HIV…

***'Blame and Banishment: The underground HIV epidemic affecting children in Eastern Europe and Central Asia'*, Unicef, 2010**

Chao, 12, turned to injecting heroin into his body after his parents were jailed for drug trafficking, his grandparents died and he was forced to live alone from eight years of age. "Someone injected me with water left in a bottle" said Chao "I felt dizzy at the beginning, but I became extremely comfortable like I'm flying in the sky." …He injected heroin four times a day into his groin…

'Hell of China's Child Drug Users', China Daily, 26 June 2012

28th September 2012

Overview

Harm Reduction International welcomes the forthcoming day on the child's right to health and commends the Human Rights Council for drawing attention to this issue. We are particularly encouraged to see a focus on children in exceptionally difficult circumstances.

Yana's and Chao's stories, quoted above, are sadly not unique. They reflect profound problems facing some of the most vulnerable children. Tied up with those vulnerabilities for many is the issue of injecting drug use, one that is over-looked when it comes to the health and wellbeing of children at risk and in the global response to HIV. In many countries, in particular in Eastern Europe and Central Asia, and in South East Asia, rates of injecting drug use are high, and injecting is often a primary driver of HIV epidemics.[1]

It is in this context that basic frontline services can help protect children and save lives – programmes aimed at reducing unsafe injecting in order to keep those most at risk safe and alive until such time that the longer term goals of addressing the underlying causes of vulnerability can be achieved. It is about protecting children from harm day to day so that long term change is possible. Too many children, like Yana, die before those solutions can be found.

Alcohol, cannabis, solvents and 'club drug' use remain much more prevalent than injecting among children and young people, but his submission focuses on injecting drug use as it continues to represent a significant blind-spot in terms of research and public health and child rights-based responses.

The need for a focus on under 18s who inject drugs is clear. There are considerable differences when it comes to implementing the child's right to health and legal, practical and ethical dilemmas raised when working with children who inject drugs that do not arise in the same way with adults.

Harm Reduction International is currently researching global data and best practices and barriers to effective intervention relating to injecting drug use among children and young people. The research is being conducted in collaboration with the London School of Hygiene and Tropical Medicine. This submission is based on some key findings to date and existing work on drug use and the rights of the child by HRI and other organisations. The full research report will be launched in late 2012 and will be available for the March discussion on the child's right to health at the Human Rights Council.

Our recommendations are rooted in right to health and child rights norms and are aimed at improving our understanding of injecting among children and young people, as well as our responses:

- **Data collection on injecting drug use among children must improve if we are to 'know our epidemic' and respond accordingly**
- **International guidance is required to support those working with children who inject drugs and to improve service delivery**
- **Legal and policy frameworks relating to drug use and service delivery must be reviewed to remove barriers to the realisation of the child's right to health**
- **Resources for frontline services for children and young people who inject drugs must be increased**

Injecting drug use among children and young people

Drug use among children and young people is a concern for governments, communities and families across the world, and reflected in multiple UN declarations and resolutions on drugs. Patterns of use and related health harms, however, are not always well understood. This is particularly true of injecting drug use among children and young people under the age of 18.

Although overall levels of drug use among young people appear to be stabilising or decreasing in many high-income countries,[2] surveys of the general population conceal the drug-related harms experienced by the most vulnerable groups

of young people – populations whose drug use is less likely to be transitory and more likely to progress onto more problematic patterns of use, such as injecting.

Children who inject drugs are often those in the most difficult of circumstances – out of school, on the streets, without family support or parental care, or with a history of inter-generational drug use, trauma or mental health problems. In many regions of the world the age of initiation into injecting now appears to be decreasing, in some cases as low as 10 or 12 years old. For some, injecting drug use is a first experience of drugs.[3]

Research consistently shows that young injectors are more likely than older ones to report sharing equipment with other injectors and less likely to access needle and syringe exchange services. Those young people who are sharing injecting equipment can transmit blood-borne viruses including HIV and hepatitis C. Young people also often have a lack of knowledge and misconceptions about HIV transmission.[4]

According to UNICEF, globally young people (under 25) account for 2,500 new HIV infections every day. According to Unicef's former head of HIV, failures to meet targets on reducing HIV transmission among young people is in a large part due to a lack of focus on unsafe injecting practices.[5] It is estimated that in countries such as Belarus, China, Italy, Poland, Spain and Russia more than half of HIV infections are due to unsafe injecting,[6] much of this among young people.

Studies from St Petersburg, Russian Federation, found that 30% of people who inject drugs were under 19 years of age, while, in Ukraine, 20% were still in their teens. A survey of Moscow youth aged 15–18 found that 12% of the males had injected drugs. Overall, up to 25% of injecting drug users are estimated to be under 20 years of age across Eastern Europe and Central Asia.[7]

Of 592 street youth surveyed in Viet Nam, across two cities, almost a third were aged 15-18. In each city, approximately 17% of street youth were injecting drugs.[8] In the Philippines a study of 468 young men who inject drugs aged 15-24 found that 12.8%, or one in eight, were under 18.[9] In Myanmar, a 2011 study showed that over 5% of people who inject drugs (60/1100) were aged 15-19. 10% were already living with HIV.[10]

Children and young people who inject are also at greater risk of other preventable diseases such as tuberculosis, as well as wound abscesses and death from overdose.

Appropriate measures to protect children who inject drugs?

That drug use among children is a health concern is clear. That it is an issue of child *rights* concern is further reinforced in the UN Convention on the Rights of the Child, which requires the protection of children from the illicit use of drugs (art. 33) – a provision that must be read alongside the child's right to health (art. 24) and the general principles of the Convention (art.s 2, 3, 6, 12).

Articles 24 and 33 of the CRC require 'appropriate measures' to fulfil the child's right to health and protect them from the illicit use of narcotic drugs and psychotropic substances, respectively. What may be considered 'appropriate measures' to address injecting drug use among children and young people is therefore a central consideration from a child rights perspective.[11] In the provisions of the CRC and existing jurisprudence on the right to health, we find a helpful normative guidance.

To begin with, in order to appreciate patterns of vulnerability and target effective responses, adequate disaggregated data is required, alongside benchmarks for monitoring of progress over time. This is recognised as a general measure of implementation of the CRC, a component of the right to non-discrimination, (art. 2), and a requirement for the tracking of progressive realisation (art. 4).[12]

A right to health framework requires that services for children who inject drugs should be available, accessible, acceptable and of sufficient quality (3AQ).[13] They must, to ensure that this is possible, be funded to the maximum of available resources (art. 4).

At the most basic level, those services should work in the best interests of children at risk (art. 3), based on the available evidence and best practice (so as to be of sufficient quality). Children should be involved in decisions about their own

healthcare (art.12),[14] and where possible consulted in the design of services, bearing in mind their evolving capacities (art. 5).

Law and policy frameworks should not act as barriers to the realisation of rights. Instead they should support services to work in the best interests of children who inject drugs, and create enabling environments for the fulfilment of their right to health. The underlying determinants of health and root causes of vulnerability (including poor or discriminatory laws and policies) must always be acted upon if a child's development in a holistic sense is to be promoted (art. 6).[15]

Based on the normative foundation above, and urgent concerns arising from our research, we have set out four basic recommendations for the Human Rights Council to consider in discussing 'appropriate measures' to realise the right to health of children who inject drugs.

1. Data collection on injecting drug use among children must improve if we are to 'know our epidemic' and respond accordingly

What is known in relation to injecting among children and young people is greatly overshadowed by what is not known. There is a severe lack of data globally on these issues. HRI's global review of data on injecting drug use among under 18s has revealed no countries where a national estimate of the number of children and young people who inject can be made with any confidence. Instead we are reliant on proxy indicators, such as, where available, statistics for those under the age of 25, small scale studies in specific cities, surveys of young drug users that may include injecting, and home and school based surveys that ask about injecting. Rarely are data on injecting drug use and related health harms, including HIV, appropriately disaggregated for age. UNGASS indicators do not request data disaggregated for those under 18.

Where data are available they often fail to capture most at risk youth. Home and school based surveys, for example, may fail to capture those outside of the home, street-involved, and/or out of education. Street-based surveys of young people should be more widely implemented to complement existing monitoring systems, alongside rapid assessments of youth injecting and its adverse health outcomes.

To use a well known mantra from HIV/AIDS – we do not 'know our epidemic'. Efforts must be taken to standardise the way we monitor the number of children and adolescents who inject drugs internationally so that we can properly 'know our response'.

2. International guidance is required to support those working with children who inject drugs and to improve service delivery

Despite a pressing need to focus on drug use among most at risk children and young people, too often generalised drug prevention campaigns, aimed at stopping children from using drugs in the first place, are the focus of responses and resources. Meanwhile, existing, high risk drug use among children is overlooked. At the same time, those working with children who inject often feel themselves conflicted about the appropriate responses, unclear of the legal situation, and unsupported by their own governments and the international community.

Documentation of best practices for working with children who inject is rare, and no high quality international guidance has been developed. Largely this is hindered by controversy and sensitivities relating to drug use among children and young people, and a related lack of political will. At the international-level, the nine core harm reduction interventions recommended by the WHO, UNODC and UNAIDS for HIV prevention, treatment care and support for injecting drug users are not youth-focused. Young people may not identify with more adult-orientated models of treatment; they may be using different drugs, and in different ways. Their legal status is different. This relates to consent to treatment, prescribing practices and other important concerns.

The UN Committee on the Rights of the Child has called attention to the fact that children who inject have not benefitted from HIV prevention services, which, where available have largely targeted adults.[16] It recently recommended the development of 'specialised and youth-friendly drug dependence treatment and harm reduction services for children and young people'.[17] International guidelines that meet the specific needs of children and young people who inject are required, as are clear child protection protocols. There is much to learn and incorporate from HIV prevention (including harm reduction services), child protection, working with street involved youth, sexual and reproductive health, mental health and other fields. Co-ordination across services for at risk children and young people is crucial.

It should be emphasised that context is key: what works in the United Kingdom and Canada, where child protection services and infrastructure are strong, may not be adequate for Nepal or Ukraine. Social policies and interventions which address the broader 'risk environment' – for example, by addressing poverty, trauma, homelessness and social exclusion – are also needed and may have the greatest impact on reducing drug related harms at a population level. As noted above, harm reduction in this context is about keeping at-risk youth alive and safe, while supporting work to address the root causes of their vulnerability.

3. Legal and policy frameworks relating to drug use and service delivery must be reviewed to remove barriers to the realisation of the child's right to health

Legal and policy frameworks relating to drugs, including: laws that criminalise children or service providers aiming to assist them; age restrictions on access to services; and issues of parental consent and the child's capacity to consent to treatment, often impede or make unnecessarily difficult work with children and young people who inject.

The UN Committee on the Rights of the Child has made clear consistently over many years that children who use drugs should be treated as victims and not criminals. Criminalising children and young people who inject drugs, through laws that criminalise personal use or possession of drugs, drives them away from services and assistance for fear of arrest or abuse at the hands of police. The Committee recently called on the Government of Ukraine, in the specific context of services for children who inject drugs to '*Ensure that criminal laws do not impede access to such services, including by amending laws that criminalise children for possession or use of drugs*'[18]

In many countries carrying paraphernalia such as a needle and syringe is sufficient for arrest and prosecution. This can and does discourage people from carrying safe equipment, hinders harm reduction services, and exposes children and young people to unnecessary contact with law enforcement. These laws, too, should be revised.

In some countries, laws criminalising the encouragement of children to use drugs or aiding them in drug use fail to incorporate safeguards for services working with young drug users. Those providing sterile injecting equipment, for example, have been accused of aiding and abetting drug use, which can carry very heavy penalties. This, in turn, can either deter service providers from helping at risk young people, or force them to resort to not asking key information from their clients, such as their age. Multiple studies that have addressed the question have shown that providing sterile equipment does not increase drug use.[19]

Removing legal age restrictions on certain services, such as sterile needle and syringe programmes, should be a priority, especially where the age of initiation to injecting is low and/or decreasing. Removing such restrictions is an important first step towards developing youth-focused services and allowing a more flexible process that is capable of taking into account the views and best interests of the child concerned.[20] Such services can also act as a first point of contact with children and young people who inject drugs, and a vital bridge to connect with drug treatment and other services. An age restriction does not allow for a basic best interests assessment to take place. Instead, rapidly applicable legal tests should be developed to determine capacity to consent to treatment without parental consent, and to allow for the best interests of the child to be taken into account.[21]

4. Resources for front line services for children and young people who inject drugs must be increased

Funding for basic, life-saving, harm reduction services is woefully poor globally and services aiming to reach and assist children and young people who inject drugs are fatally under-resourced. It is imperative that there is sufficient funding and training to support new responses focused specifically on the special needs of young people at highest risk from drug use. The UN Secretary General has already identified that this is a major problem in Asia, where 90% of the resources for young people are spent on low-risk youth, who represent just 5% of those who go on to become infected with HIV.[22]

Harm Reduction International, meanwhile, estimates that in low and middle income countries, funding for basic HIV prevention services for people who inject drugs must scale up approximately twenty-fold to meet basic need.[23] The amount of money spent on under 18s who inject drugs globally is not known, nor is an estimate of what is required to meet their needs. With the global financial crisis continuing to have an impact, in the coming years it is likely that more children and young people will be at risk. What we do know is that basic frontline harm reduction services save lives, improve health, and represent clear value for money.[24] Increased investment in protecting children and young people who inject drugs is needed as a matter of urgency.

About Harm Reduction International

Harm Reduction International (HRI) is a leading non-governmental organisation working to reduce the negative health, social and human rights impacts of drug use and drug policy – such as the increased vulnerability to HIV and hepatitis infection among people who inject drugs – by promoting evidence-based public health policies and practices, and human rights based approaches. We are an influential global source of research, policy/legal analysis and advocacy on drug use, health and human rights issues. www.ihra.net

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ENDNOTES

[1] Global State of Harm Reduction 2012: Towards an integrated response' Harm Reduction International, 2012.
[2] See *World Drug Report 2009*, United Nations Office on Drugs and Crime, 2009.; A. Fletcher et al 'Young people, recreational drug use and harm reduction, in European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) *Harm reduction: evidence, impacts and challenges* (pp. 357–378). Luxembourg: Publications Office of the European Union; B. Hibell et al *The 2011 ESPAD Report: Substance Use Among Students in 36 European Countries*. Stockholm: The Swedish Council for Information on Alcohol and Other Drugs.
[3] *Young people and injecting drug use in selected countries of Central and Eastern Europe*, Vilnius, Eurasian Harm Reduction Network, 2009
[4] Ibid
[5] 'Call for AIDS focus on children and injecting drug users' The World Today, ABC, 10 June 2011.
[6] *Global Report: UNAIDS report on the global AIDS epidemic 2010.* Geneva: UNAIDS., 2010
[7] UNAIDS (2003). *AIDS epidemic update: 2003*. Geneva: UNAIDS.
[8] Institute for Social and Medical Studies 2010. Evaluation Study of the Street Youth HIV Prevention Project N.A.M. Vietnam: Save the Children.
[9] Department of Health 2009. Youth Injecting drug users - 2005-2009 Integrated HIV Behavioral and Serologic Surveillance. Manila: Department of Health, Republic of the Philippines.
[10] Ministry Of Health, Results of HIV Sentinel Serosurveillance 2011, Myanmar. National AIDS Programme, Department of Health, Ministry of Health.
[11] For a more detailed discussion see 'Drug use, drug dependence and the right to health under the UN Convention on the Rights of the Child: Submission to the UN Committee on the Rights of the Child: General Comment on Article 24', Harm Reduction International, 15 December 2011. See also D. Barrett and P. Veerman, *A Commentary on the UN Convention on the Rights of the Child: Article 33, Protection from Narcotic Drugs and Psychotropic Substances.* Leiden, Brill/Martinus Nijhoff, 2012.
[12] UN Committee on the Rights of the Child, General Comment No. 5 *General Measures of Implementation of the Convention on the Rights of the Child* (UN Doc No CRC/GC/2003/5, 2003).
[13] UN Committee on Economic Social and Cultural Rights, *General Comment No. 14: The right to the highest attainable standard of health*, (UN Doc No. E/C.12/2000/4, 2000).
[14] UN Committee on the Rights of the Child, *General Comment No. 12: The right of the child to be heard*, (UN Doc No CRC/C/GC/12, 2009)
[15] '*Article 6: the child's inherent right to life and States parties' obligation to ensure to the maximum extent possible the survival and development of the child. The Committee expects States to interpret "development" in its broadest sense as a holistic concept, embracing the child's physical, mental, spiritual, moral, psychological and social development. Implementation measures should be aimed at achieving the optimal development for all children'* General Comment No. 5 op. cit. p.4.
[16] UN Committee on theRights of the Child, *General Comment No. 3 : HIV/AIDS and the Rights of the Child*, (UN Doc No CRC/GC/2003/3, 2003)
[17] UN Committee on the Rights of the Child, *Concluding Observations: Ukraine*, (UN Doc No CRC/C/UKR/CO/4, 2011), paras 59 & 60.
[18] Ibid.
[19] See World Health Organization 'Effectiveness of Sterile Needle and Syringe Programming in Reducing HIV/AIDS Among Injecting Drug Users.', 2004
[20] For an overview of age restrictions on harm reduction services see A. Fletcher 'Excluding Youth? A global review of harm reduction services for young people', in *The Global State of Harm Reduction*, 2012
[21] For example, Gillick v West Norfolk and Wisbech Area Health Authority [1985] 3 All ER 402 (HL) which set out a five step test that has since been applied in the UK relating to access to sexual and reproductive health services without parental consent.
[22] 'Uniting for universal access: towards zero new HIV infections, zero discrimination and zero AIDS-related deaths: Report of the Secretary General' (UN Doc No A/65/___, 2011) para 16.
[23] *3 Cents a Day is Not Enough: Resourcing Harm Reduction on a Global Scale* Harm Reduction International. 2009.
[24] See 'Harm Reduction: A Low-Cost, High-Impact Set of Interventions' (Poster), Harm Reduction International, 2010.