COSTING CRIMINALISATION

Building the Economic Case for LGBTIQ Inclusion and the Decriminalisation of Drug Use

Case Examples
from Indonesia, Malaysia,
Thailand and the Philippines

SHIFT
Sustainable HIV Financing in Transition

Sustainable HIV Financing in Transition (SHIFT) Programme

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About SHIFT

The Sustainable HIV Financing in Transition (SHIFT) Program is a Global Fund-supported two-year regional advocacy program that aims to enable and empower civil society, including communities of HIV key populations, to advocate for sustainable HIV financing, especially in light of the changing international HIV funding landscape. The four countries covered in the program are Indonesia, Malaysia, Philippines and Thailand.

The SHIFT Program has three key objectives:

- Support CSO advocacy for sustainable HIV financing in the four countries and in regional and international platforms;
- Enhance the capacity and technical skills of civil society and communities of HIV key and vulnerable populations to advocate for increased allocative efficiency in HIV financing, increased domestic HIV funding, and improved fiscal space for CSO HIV programs; and
- Facilitate access and use of strategic information on HIV financing

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Executive Summary

Recent years have seen a conservative backlash and a rise in populism across the political front, perpetuated more intensely in this digital age where society is becoming more divided into echo chambers of the liberal Left versus the conservative Right. The successes of social justice movements for LGBTIQ people, such as the repeal of anti-gay laws Section 377 in India, the move towards marriage equality for same-sex partners in Taiwan and Thailand, and drug policy reforms in support of harm minimisation, are often met with equally astounding backtracks in other parts of the region. Key examples include the situation for LGBTIQ people in Indonesia and Malaysia, and the "War on Drugs" in the Philippines.

LGBTIQ people and people who use drugs are often also employed as political scapegoats, easy targets to stoke public fears of an imaginary enemy, and one used with great precision as seen in the politicising of LGBTIQ rights as against traditional culture and religious values, and the "War on Drugs" as one of strong leadership. Mass media particularly social media further fuel these divisions, rewarding the most outrageous comments or more jarring statements with more clicks and likes, sometimes to the detriment of real facts and figures.

Reflecting on the realities that we exist in, making an economic case for LGBTIQ rights and drug policy reform is all the more important, not as a silver bullet, but as an additional tool to complement the ongoing human rights advocacy push. Be it a way of strategy or an alternative narrative to frame human rights approaches, the dollar value in its simplistic, emotional language, cuts through the noise and gets noticed in this era of clickbaits and post-truth. It is with this approach that this report is grounded in, with the aim to share preliminary findings, as well as to cultivate interest and to galvanise further research.

What is the scope of this report?

The shrinking HIV funding environment presented an opportunity to approach human rights through an economic lens. A key focus of policy-makers and governments is the issue of maximising the impact of limited public funds in an efficient manner, by investing in the right populations and right interventions to end HIV[1]. The SHIFT program, with its focus on advocating for efficient allocation of limited health resources and key populations[2] focused investments, conducted this Cost of Criminalisation Project to cost the impact of criminalising LGBTIQ people and drug use.

This report sets out country specific case examples on the cost of criminalising drug use in Malaysia, Thailand and the Philippines, and persecution of LGBTIQ people in Indonesia. It brings together the preliminary research findings undertaken by country partners and their respective consultants. The focus of these studies span both drug use and LGBTIQ rights, a priority determined by country partners in consultation with key population communities they work with. While the issues are disparate, it is a necessary response to the local context in light of domestic developments with the "War on Drugs" and persecution of LGBTIQ people in these countries.

Who is this for?

This report presents preliminary evidence to make the case for decriminalisation of drug use and for LGBTIQ inclusion. For those working on national economic policy, it provides evidence for the link between economic and health outcomes, providing quantitative "dollar value" evidence derived from cost analysis. For those seeking to end LGBTIQ persecution and discrimination, and to make drug use a public health issue as opposed to criminal justice response, this report highlights the economic argument and its application in human rights advocacy. Additionally, informed by current socio-political contexts and domestic developments, costing the impact of criminalisation on these communities serve to put centre stage the issues facing LGBTIQ and people who use drugs, marking an alternative and complementary strategy to rights-based advocacy, as well as a justification for better use of tax payer dollars.

What are the methods?

The criminal justice response to drug use and policing of LGBTIQ people is a high cost-low gain exercise. Public health approaches such as needle syringe programs, methadone replacement therapy and the investment in prevention modalities for MSM and transgender people are supported by a strong evidence-based, and shown to be effective and of value for money[3].

With a view to contribute to the evidence base, the research profiled here employed a cost analysis of the criminal justice approach, comprising the cost of prisons, policing and associated legal and administrative costs. Where data is available, this cost is then compared to the cost for methadone assisted therapy, needle syringe programs and for the case of MSM and transgender people, the cost of anti-retroviral medicines and other medical costs. Cost was estimated based on data obtained from primary sources and secondary data available in the public domain. Secondary data was further validated from relevant stakeholders such as the national drug enforcement agencies, legal and police departments.

Where there is sufficient data, a final comparative analysis was undertaken to compare the cost of a criminal justice approach of policing or incarceration, versus the public health approach of harm minimisation for drug use, and decriminalisation of same sex activity for LGBTIQ people.

Any limitations?

Costing the impact of criminalisation is a relatively new area of research enquiry, with the extant research and analysis using projected estimations based on other comparable data. An example from a study done on the economic effects of LGBTIQ exclusion in Indonesia draws on estimations from a study in India, which projected the cost of LGBTIQ exclusion from 0.1% to 1.4% of the Gross Domestic Product (GDP). Applying these percentages to the Indonesian GDP projected a loss of almost $900 million to $12 billion[4].

Studies such as these however illustrate the common limitation of available and accurate data to cost the impact of criminalisation. To illustrate the cost to GDP for example, there is a need for accurate population size estimations of MSM and transgender people. However, there is no extent LGBTIQ demographic data collection conducted in Indonesia. The research conducted in Indonesia instead focused on the cost of persecution on a per case basis, comparing this cost to the provision of medical services to PLHIV to make its case, instead of the overall cost to GDP and the country.

In the case of criminalisation of drug use, in addition to availability of accurate size estimations, obtaining data on client numbers or number of prisoners on drug offences was also a challenge. This is reflected in the findings in the following section.

Many of the research undertaken by country teams are also qualitative in nature, exploring the perceived impact or cost to the individual facing criminalisation. While this mode of enquiry does not produce hard numbers, it highlights the importance, and difficulty of converting the impact of stigma and discrimination, and opportunity costs into dollar value.

This project is also an exercise in community-based participatory research (CBPR), one that draws on active participation of communities both in its design as well as execution, sharing in the decision-making, ownership and dissemination of the research findings. While these studies did not have the benefit of high level econometric or Return on Investment (RoI) analyses by virtue of its small scale, time and resource limitations, these studies are a timely intervention as it is driven not from research institutions or INGOs, but through communities and partnership with local researchers. The research presented here is an exploratory first step, as a complement to academic and institutionally sponsored studies, and with hopes to further catalyse studies in the development of evidence-based strategic information to inform sound public policies.

1. This concept is termed Allocative Efficiency, defined in SHIFT as "…investing available or anticipated additional funds to the right HIV interventions or programs and targeting appropriate groups in such a way that leads to an optimal outcome for the HIV epidemic"
2. Key populations in HIV refers to: gay men and other men who have sex with men (MSM), transgender people, people who inject drugs (PWID), sex workers and incarcerated people, available at http://www.unaids.org/en/topic/key-populations.
3. UNDP (2012). Global Commission on HIV and the Law – Risks, Rights and Health, available at https://hivlawcommission.org/wp-content/uploads/2017/06/FinalReport-RisksRightsHealth-EN.pdf
4. Badgett, M.V.L., Hasenbush, A. & Luhur, W.E. (2017). LGBT Exclusion in Indonesia and Its Economic Effects. Williams Institute, UCLA School of Law, available at https://williamsinstitute.law.ucla.edu/wp-content/uploads/LGBT-Exclusion-in-Indonesia-and-Its-Economic-Effects-March-2017.pdf

What are the findings?

COUNTRIES	KEY POPULATION FOCUS
Indonesia	MSM & Transgender
Malaysia	People who inject drugs
Philippines	People who inject drugs
Thailand	People who inject drugs

5. Tanguay, Pascal. 2016. Evaluation of Harm Reduction Service Delivery in Cebu City, Philippines (2013–2015). World Bank, Washington, DC., available at: https://openknowledge.worldbank.org/handle/10986/24750
6. Winn, P. 9 April 2018. "A US-style drug war brings a terrible cost: Thai prisons packed full of women" in Public Radio International, available at: https://gpinvestigations.pri.org/a-us-style-drug-war-brings-a-terrible-cost-thai-prisons-packed-full-of-women-f25086769bcd.
7. Winn, P. 9 April 2018. "A US-style drug war brings a terrible cost: Thai prisons packed full of women" in Public Radio International, available at: https://gpinvestigations.pri.org/a-us-style-drug-war-brings-a-terrible-cost-thai-prisons-packed-full-of-women-f25086769bcd

KEY FINDINGS	METHOD
Rp. 20.407,549 (USD 1425) - Cost of legal process per person (including arrests and serving prison sentence). This amount can fund the clinical management and treatment of 4 PLHIV for a year.	Qualitative research (FGD, interviews), Cost analysis
RM20,690 (USD4,900) -Annual cost of prisons per offender. RM5,340 (USD 1,287)- Annual cost per person for Methadone Assisted Treatment (MAT). Based on available government data of number of offenders in 2015, if the total number of incarcerated individuals were put on the publicly-run MAT programme, this will result in cost savings of nearly RM439 million in the first year and RM455.4 million in the second and subsequent years	Cost Effectiveness Analysis, Case comparisons
No conclusive data as the pilot needle syringe project initiated only for five months, between December 2014 and April 2015 when the services were suspended due to political pressures after the installment of President Duterte. However, the study quoted an evaluation of the project[5], with promising findings of high needle syringe uptake of 16 needles per client per month in the short period of time. If the services were sustained and maintained, this would equate to 196 needles per client per year, considered high by UN guidelines. Given that estimated cost savings for 100 needles per person per year is at USD 2,300,000, a consistent high coverage of 196 needles per person per year saves almost USD 4,600,000 or PhP 248,400,000.	Qualitative research, cost analysis
Voluntary treatment system (methadone replacement) costs 51,032 baht per case (USD 1,600). Forced treatment system (combination of methadone replacement and detention) cost 108,644 baht per case (USD 3,414). Criminal system (incarceration) costs 44,110 baht per case (USD 1,386) Although the criminal system costs less per case than the harm reduction route, an estimated $3.1 billion was spent on criminal justice components of drug control in 2015[6], compared to a measly $340 million spent on public health responses to drugs. That represents over 90% of resources being allocated to law enforcement, and less than 10% to health initiatives, out of which just 0.05% was spent on harm reduction among people who use drugs that same year[7].	Qualitative research (interviews), Cost analysis

Discussion

More than just a rhetoric on the inalienable rights of every human being, the economic argument for an inclusive society presents fundamental questions and evidence that more inclusive societies are better off economically and socially. In a study analysing the social inclusion of LGBTIQ people in 39 emerging economies, countries with more rights for LGBTIQ people see an increase of 3% on average GDP per capita. This translates to an additional USD$320 a person makes for every right enshrined, a testament to more productive societies where every member of society can exercise their full potential[8].

Criminalisation is also a powerful driver of the HIV epidemic. A 2017 study published in the ***Lancet*** "showed clear patterns of criminalisation having negative effects on HIV prevention and treatment at the individual, programmatic, and population level."[9] The Global Commission on Drug Policy has also underlined that "fear of arrest drives persons who use drugs underground, away from HIV testing and HIV prevention services and into high risk environments." [10]

Looking at the Return on Investment as a further advocacy lens for decriminalisation, the Australian response is a well published example. Between 1988 and 2000, the Australian government spent A$150 million on harm reduction programs, preventing an estimated 21,000 HIV infections and 25,000 hepatitis C infections. The program saved around 4,500 lives that would have been claimed by AIDS and 90 by hepatitis C. And, for every dollar spent, the government saved A$4 in health-care costs and A$27 in the lost economic contribution of drug users and the cost of drug use to the user themselves[11].

However, the indirect costs associated with incarceration and institutionalising offenders are more difficult to estimate. Former prisoners, incarcerated even for small drug offences, are often stigmatised post-release from prison, making their reintegration into society more difficult.

8. Badgett, M.V.L.; Nezhad, S.; Waaldijk, C.; Meulen, Rodgers Y. van der (2014). The Relationship between LGBT Inclusion and Economic Development: An Analysis of Emerging Economies. https://openaccess.leidenuniv.nl/handle/1887/37240
9. DeBeck, K. et al. 2017. "HIV and the criminalisation of drug use among people who inject drugs: a systematic review" in The Lancet, 4: e357–74. (http://www.hivlawandpolicy.org/sites/default/files/DeBeck_HIV%20and%20the%20criminalization%20of%20PWID.pdf)
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Recommendations

In light of the preliminary research presented here, there is a clear call for more investments into economic research in a comprehensive strategy for human rights advocacy. Some recommendations include:

- Economic analysis and the use of mathematical modeling to account for total cost of criminalisation to the country/health system. A need to expand the cost per person findings and extrapolate the data to changing epidemiological trends, key population size estimates, client numbers and other demographic indicators.
- A call for more rigorous data collection both from researchers and government agencies, and the sharing of demographic data for research and policy use.
- Use different economic outcome measures to compare against LGBTIQ inclusion, such as GDP growth rates, tourism measures, and foreign direct investment.
- Further the quantitative evidence base for decriminalisation by studying the social determinants of health, and approach the quantification of health outcomes and burden of disease through the metrics of Disability-Adjusted Life Years (DALY) and Quality-Adjusted Life Years (QALY).
- Further enquiry into the direct vs indirect costs, opportunity costs, latent cost of criminalisation in areas of health care access, education, employment, housing, social insurance etc.
- Expand the studies to a broader set of key populations and countries, further account for differences in size and experiences of the communities studied, including workforce participation, provision of health care, education and other social determinants of health.
- Study the determinants of legal rights for LGBTIQ people, people who use drugs and other key populations.
- To further expand the economic research into people who use drugs beyond a focus on opiods, to encompass Amphetamine Type Stimulants (ATS) use. There are limited research and interventions looking into ATS use in relation to health care cost and necessary investments in light of a shift in substance use in the region.
- Create a database of existing research from a wide variety of countries, both as a basis for additional comparisons and to inform the creation of new indicators.

ANNEXE 1

Executive Summary Country Report of Indonesia

Economic Analysis of the Practice of Criminalization of Groups of Men Who Have Sex with Men (MSM) and Transgender (TG) in Indonesia: Preliminary Study

In a report entitled State-Sponsored Homophobia: A World Survey of Sexual Orientation: criminalization, protection and recognition in 2017, International Lesbian, Gay, Bisexual, Trans, and Intersex Association (ILGA) qualifies Indonesia as a state that illegalizes same-sex sexual behavior. LGBT institutionalization as a criminal offense was found in several regions, in accordance with the records of the National Human Rights Commission (Komnas HAM), namely South Sumatra Province, Palembang City, Banjar Regency, Tasikmalaya Regency, and Padangpanjang Regency. At the national level, institutionalization efforts in criminal law were adopted by the Cinta Keluarga Alliance through the drafting of the Criminal Code after failing to include homosexuality in the category of criminal abuse through the lawsuit of Article 292 of the Criminal Code to the Constitutional Court in 2016. This situation shows a crisis of sexuality and gender diversity in the formulation of legislation in Indonesia.

Although there is no national criminal law framework that covers various actions of law enforcement officials to MSM and TG groups in Indonesia, the treatment that leads to criminalization generally refers to the availability of criminal law instruments in conventional regulations or criminal law systems regulated in the Criminal Code and Criminal Procedure Code. This practice continues even though there is never a way to measure benefits, let alone its success in preventing the spread of HIV / AIDS in the community. Instead, this policy rests on a stigma of homophobia which results in various acts of human rights violations for groups of MSM and TG. On the other hand, empowerment programs and health services for MSM and TG groups have not been maximally implemented while discrimination treatment is still often experienced in various sectors such as education, health, and employment.

This study was conducted with the intention of identifying estimates of costs that the State must devote when taking actions that lead to criminalization of groups of MSM and TG. Cost analysis gives an analysis orientation to the amount of financing that is 'sacrificed' by law enforcement agencies around the stages of arrest, detention, and imprisonment. In the field, there has not been a case where a person has been convicted because of his sexual orientation, but many LSL and TG groups have to face the authorities bawah below 'legal norms about sexual abuse or adultery and pay fines to be free from detention. Sometimes they also have to get violent acts and even molestation from law enforcement officials themselves. In this case, the practice of criminalization also had the effect of financing which must be sacrificed by groups of MSM and TG.

For MSM or TG, the State must at least allocate a fee of Rp. 20.407,549, -, if the entire legal process from arrest to serving a prison sentence is experienced. These costs are summarized from four agencies, namely the Police, the Attorney General's Office, the Supreme Court, and the Ministry of Law and Human Rights with allocations for legal assistance and prisons. The budget is equivalent to allocating the cost of treatment of four people with HIV as well as the components of the drug ranging from reagents, antiretroviral (ARV), CD4 and viral load test. The legal process fee for an MSM or TG is equivalent to the allocation of 58 bottles of ARV which can be used to meet the needs of medicines for four PLWHA in a year.

The MSM and TG communities also incur their own costs due to the criminalization practices they experienced. Criminalization cases against MSM and TG groups are generally handled in accordance with the handling of minor crimes. The financing component issued generally includes a fine of Rp. 100,000, -. On the other hand, most cases of criminalization only arrived at the police detention stage. For this matter, an MSM and TG need to pay the exemption fee with a varied amount starting from Rp. 10,000, up to Rp. 350,000. Sometimes, the officers also intimidate and threaten violence so that an MSM or TG must pay a fee of Rp. 1,000,000 - to reduce the disturbance. This information was obtained through interviews with 24 informants in Bandung and Semarang. The average income of all informants interviewed was only Rp. 3,689,625, - per month so that the costs incurred due to the criminalization practices experienced by MSM and TG groups are actually very significant for their lives.

Actions that led to criminalization gave birth to various sufferings and human rights violations for groups of MSM and TG. Allocation of costs incurred by MSM and TG has the potential to cut off access to the fulfillment of other rights for themselves such as the right to food, right to housing, the right to access health services, and so on. On the other hand, the costs incurred by the State are also not commensurate with the results obtained because with various violations committed by the authorities means that the State must incur additional costs to recover the rights of MSM and TG that are violated. The practice of criminalization is also counterproductive to the Three Zero vision (zero new infection, zero stigma and discrimination, and zero death) because it creates a chilling effect (the effect of extraordinary fear) among MSM and TG communities to access Government health programs. Criminalization actually strengthens the negative perception of the community towards MSM and TG communities.

Indonesia does not yet have a protection and recovery mechanism for MSM and TG groups who have been criminalized by the authorities. In fact, this mechanism is important provided by the State to prevent the domino effect of criminalization practices that have greater financing potential. In addition, health service programs, especially reproductive and sexual health for MSM and TG are not oriented to empower communities and increase public awareness about the diversity of sexuality. Prevention of sexually transmitted diseases and HIV / AIDS should not be done with the approach of criminal law but must be started by building legal infrastructure and policies that are inclusive and friendly towards diversity of sexuality. The discourse of criminalization of MSM and TG, and other sexual minority groups in general, must be stopped because it does not have a real effect on improving community welfare and social development.

ANNEXE 1

Based on this, we recommend several things that the Government must:

1. Guarantee, ensure, and implement respect, protection and fulfillment of the human rights of all citizens without exception, including sexual and gender minority groups, in order to carry out the Government's commitment to the 1945 Constitution and recognized international human rights instruments .
2. Guarantee, ensure, and implement respect, protection and fulfillment of the human rights of all citizens without exception, including sexual and gender minority groups, in order to carry out the Government's commitment to the 1945 Constitution and recognized international human rights instruments .
3. Evaluating the existence of regional regulations which contain discriminatory articles based on sexual orientation and certain gender expressions.
4. Ensure Joint Regulations of the Minister of Law and Human Rights and Minister of Home Affairs No.20 of 2012 and No. 77 of 2012 concerning Parameters of Human Rights in the Formation of Regional Legal Products effectively implemented to encourage the birth of inclusive and human rights-friendly regional regulations.
5. Providing adequate budget allocations for the development of sexual and reproductive health services to sexual minority groups, especially MSM and TG, to guarantee the right to health which includes health facilities, facilities and infrastructure services; health information; access to medicines, especially for MSM and TG with HIV / AIDS; and building an equal and accessible health protection system for vulnerable groups, especially MSM and TG groups.
6. Ensure that the implementation of sexual and reproductive health education programs runs effectively and is based on in-depth studies, involving sexual and gender minority groups.
7. Improving the quality of bureaucratic services by improving the quality of human resources through inclusive education based on equality and sexual and gender diversity.

ANNEXE 2

Executive Summary Country Report of Malaysia

Cost of Criminalizing Drug Use in Malaysia

Introduction

Malaysia continues to spend a considerable amount of resources and funds in its enforcement efforts to address the drug problem in the country. This enforcement based efforts are not only focussed on supply reduction but also on demand reduction activities. Criminalizing and sending people who use drug (PWUD) and detention centres have not only been unsuccessful but also cost far more than the other alternatives available. In this note, we compared the estimated costs of sending PWUD

1. To Prison
2. To Community care and rehabilitation centres (institutional rehabilitation program also known as CCRC)
3. For opioid treatment.

Cost computation

The estimated costs for the first two approaches were obtained from a report published by Agensi Inovasi Malaysia (March 2017). The cost for the third approach was estimated based on our fieldwork.

The cost of sending an arrested PWUD to prison consists of four components – police, court and medical care, prison care followed by post-release supervision and half-way house. The total cost per PWUD based on the assumption that a PWUD is sentenced to 1 year in prison is estimated to be RM 20,690.

The cost of sending PWUD to community care and rehabilitation centres (institutional rehabilitation program) consists of four components – police/ AADK, court and medical care, CCRC, followed by post-release supervision and half-way house. On the assumption that a PWUD spends 2 years in this institution and another 2 years of post-release supervision, the estimated cost is RM 38,530 per PWUD.

The cost of methadone treatment at an average dose of 60mg per day, per patient, per year is calculated based on three components, that is, cost of medicine, material cost and supervision cost. The total cost is estimated at RM 682.50. Alternatively, if the PWUD is treated with buprenorphine (suboxone) at a daily dose 4mg, the cost per patient per year is RM 7502.70.

Conclusion

It is clear that sending a PWUD for treatment is by far the cheapest approach. It is more cost effective than sending a PWUD to prison or keeping a PWUD in an institutional rehabilitation program. While one can argue that sending a PWUD to CCRC is part of rehabilitation these approaches stigmatizes an individual making reintegration into society more challenging. There are also studies to show that the relapse rates of PWUD from prisons and CCRC are high as compared to those undergoing treatment.

ANNEXE 3

Executive Summary Country Report of Philippines

When Laws Kill: Cost of Criminalization of People Who Inject Drugs in Cebu City to the HIV Response

With current global trends, the Philippines is one of the countries in Asia and the Pacific with majority of occurring infections.[1] From 1984 to December 2016, the Philippines girdled 39,622 HIV cases.[2] This has increased tremendously in December 2017 with 50,725 cumulative total.[3] Across the country, Cebu City ranks third in bearing the most number of cases.[4] As of December 2016, a total of 2,648 HIV cases were reported.[5]

Based on the latest release of the Department of Health's Epidemiology Bureau, a total of 57,134 HIV cases has been reported from January 1984 to July 2018. This accounts to 31 newly diagnosed persons with HIV per day.[6]

Looking back, there has already been an increasing prevalence of HIV among PWID in 2010. This prompted the World Health Organization to explore possibilities of delivering a comprehensive package of treatment, care and support services for PWID.

Through the generous assistance of the Asian Development Bank and the World Bank, Population Services, Inc. was contracted in March 2013 to lead the implementation of the Big Cities Project.[7]

The ultimate goal of the project was to reduce HIV transmission by reducing risk behaviors among MSM and PWID.[8] Specifically, implementation of the BCP aimed to develop friendly drop in centers (DICs) and outreach services; increase demand and uptake of health services through improved peer education and support; and strengthen governance for development and implementation of sustainable.[9]

The package of services under the Operations Research arm of the BCP included basic health services, demand reduction services and community development services.[10]

Through the Dangerous Drugs Board's Board Resolution No. 298, the distribution of needles and syringes for medical research purposes was allowed and reduced operational risks by making Barangay Kamagayan a safe zone.[11]

In March 2013, the Asian Development Bank and the World Bank contracted Population Services, Inc. to implement the Big Cities Project, from April 15, 2013 to December 31, 2015, which was designed to develop and strengthen HIV prevention service delivery models targeting MSM in Metro Manila and PWID in Cebu City.[12] ADB committed a total of USD1,840,000 for April 2013 to December 2014 and an additional USD500,000 from April 15, 2013 to December 31, 2015.[13] While the total project timeline represents 32.5 months, the original expectation was to implement the operations study, embedded in the BCP, for a period of 24 months.[14]

Specifically, based on the National AIDS Spending Assessment[15], about PhP18,912,827 or USD420,949.20 was utilized for the PWID-OR component of the BCP.

On the other hand, for 2017[16], DDB allocated PhP 64,623,000 for the said operations while PhP 91,329,000 was allocated for 2018.[17]

The PDEA, on the otherhand, allocated PhP 1,556,936,000 and PhP2,395,095,000 for 2017[18] and 2018[19] respectively, for the operation of the Dangerous Drugs Supply Reduction and Suppression Program.

Among the identified achievements of the OR were:

1. Legitimizing harm reduction services and the OR[20]
2. DDB's Resolution 298
3. Mobilization of local government support for the PWID
4. Access to a comprehensive package of health services
5. "Controlled" spread of infections
6. Voluntary submission to residential treatment
7. Engagement of clients and providers
8. Confidentiality was observed all throughout

CHALLENGES

1. Limitations of the law
2. The OR was highly politicized
3. No substantial data established
4. Location
5. Geographical coverage
6. Clients avail services while under drug influence
7. Lost to follow up

When Duterte was inaugurated as the newly elected President of the Republic of the Philippines in mid-2016, the Philippine War on Drugs was resurrected and has greatly been intensified.

With the war on drugs notoriously intensified, the following systems are currently in place for the treatment, care and support of PWID in Cebu City:

1. Service delivery targeting PWID in Cebu with Global Fund support are currently being continued. HIV and Care Treatment are being provided among PWID with HIV through Cebu Plus.
2. In the municipality of Talisay, the Rural Health Unit (RHU) installed a community- based care and treatment program for PWID with HIV. Once PWID enroll in their program, clients are automatically tested for HIV.
3. The peer education component of the BCP gave birth to IDU Care. It is a peer-led community-based organization that established a drop-in center within the parameters of a church in the area.
4. The City Health's Social Hygiene Clinic continually provides treatment and care services for PWID except the NSP.
5. Under DDB and DILG's Joint Memorandum Circular No.1 signed last May 2018, all barangays in the Philippines are accountable in institutionalizing community-based program intended to address drug concerns within their own localities.

COST OF CRIMINALIZING PWID

1. Increasing animosity between PWID and government especially law enforcers
2. Non-humane and judgmental policy amendments
3. Lack of government support for key affected population i.e. PWID
4. Non-confidential handling of information
5. Compulsory drug detention and rehabilitation of people who use drugs
6. Drug-related deaths
7. Punitive measures in responding to drugs
8. Stigma and discrimination
9. Lack of access to a comprehensive package of health services
10. Non-adherence to treatment
11. Fast growing number of infections

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ANNEXE 4

Executive Summary Country Report of Thailand

The Study on Cost Criminalization against People Who Use Drugs (PWUD) in Thailand

Extent of Thai laws criminalizing drug use, possession, distribution/selling

Legal Measures and Criminal Procedures in the Crime Base for Drug Abuse, Possessing for use or for commercial purpose

The Thai Cabinet resolved to propose the draft of the Act in using the Code of Drug B.E..... to the National Legislative Assembly due to the reasons and necessities from the law related to the prevention, suppression and control on narcotics as well as the treatment and rehabilitation of drug addicts as referenced in various laws. The implementation in accordance with each law is the duty and authority of many organizations resulting in inconsistent law enforcement. In addition, some provisions of laws on drugs are not appropriate for the current situation. The mentioned laws should be incorporated into the Code of Narcotics for the purpose of systematically applying the law. At the same time, the provisions of laws have been amended to suit the current situation. In addition, it is necessary to enable the efficient control and use of drugs for medical, scientific, and industrial purposes, as well as focusing on preventing the spread of illegal, addictive drugs and drug use, especially among teenagers. This also requires a system of committees consisting of diverse personnel from both the public and private sectors to participate in policy-making on the issues related to drug prevention, control, and suppression. This also includes the efficient treatment and rehabilitation of drug addicts' social status.

Laws related to drugs and the legal process in conducting drug abuse detection

Drugs of Category 1 include heroin, methamphetamine (amphetamine), MDMA (Ecstasy) without medical benefits. The Narcotics Act B.E.2522,

Section 15, states: "No one is permitted to manufacture, import, export, distribute, or possess narcotics of Category 1".

Section 67 states: "Any person who has possession of narcotics of Category 1 without permission will be imprisoned from 1 year to 10 years or will be fined from 20,000 baht to 200,000 baht, or both. Any person who possesses the narcotics of Category 1 for distribution will receive a penalty from 4 years to life imprisonment."

Section 91states: "Any person who uses narcotics of Category 1 shall be imprisoned for a term of between six months and three years, fined from 10,000 baht to 60,000 baht, or both."

Guidelines and policies for solving the drug problem in Thailand: The legal mechanisms related to the enforcement of anti-narcotics regulations should be enacted. There are also several drug enforcement agencies whose staff are integrated across the administrative, military, and police organizations. According to Sections 65-67 of the Narcotics Act, the possession of 15 or more tablets [of illegal narcotic] or 15 units of usage will be considered by law as possession with intent to sell. The highest penalty is life imprisonment and a fine of 1-5 million baht. If the offender is found to possess drugs, presumably for sale, the ultimate penalty is death. Being 'presumed,' legally pushes possession to intent to sell, with severe consequences. However, the legal mechanisms cannot effectively manage the myriad drug issues and, thus, the number of accused and detainees increases. In addition, the nature of the laws makes it easier to arrest drug users, while the retailers and major traffickers are rarely apprehended.

According to the report on the statistics of inmates around the country, on 1st March, 2018 there were more than 200,000 inmates in drug cases nationwide including the inmates in the cases of drug addiction and drug trade which represents over 60% of all inmates. There were also more than 30,000 inmates whose cases were pending. According to the statistics of inmates with offenses against the Narcotics Act of the Information Technology Center of the Department of Corrections in August 2017, more than 36,000 inmates were convicted of drug addiction, possession, or possession for use. This reflects the fact that Thailand's narcotics suppression policy emphasizing compulsory sanctions and detention results in a continuous increase in the number of inmates. Thus, the Thai prison system is seriously overcrowded.

Thailand has the absolute presumption that drug addicts or those who possess drugs (more than the defined limit) will be punished and immediately prosecuted. However, there is an amendment to the penalty of the offender as addict according to Section 57: (…prohibition of possession and abuse. If you have possession for abuse, it must not be more than 5 tablets or 5 units of usage). In those cases, the offenders will enter the recovery process in accordance with the Drug Addict Rehabilitation Act B.E. 2545 which also avoids a criminal penalty. Moreover, Thailand also has a drug problem-solving system which is similar to Portugal that includes rehabilitation and treatment guidelines for drug addicts. In Thailand, there is a rehabilitation and treatment program for drug addicts to determine the place, procedure and methods for rehabilitation of drug addicts to suit their condition. However, the limitations of Thailand's program are that the agencies in the rehabilitation process have a different understanding of the rehabilitation process, and the rehabilitation approaches and process are limited in various issues which are not covered by law. For example, the examination of the investigating officers under Section 19, Paragraph 1, which is based on the legal exception, is the force majeure in the timely submission of the accused. The accused must be released until the evidence is complete, at which time they are re-arrested. Thus, many of the accused are driven into a cycle of repeat offense, and they do not receive timely rehabilitation. In addition, the scope of treatment is limited to the possessors of 5 tablets of drug only, while in other countries there are more forms of therapies resulting in a reduction in the number of drug abusers.

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Lessons from other countries: The Portuguese lesson reflects that the exemption on criminal penalties for drug addicts and use of administrative measures together with public health interventions under the Decriminalization Policy. That means that the offense status in the narcotic case is not criminal. The detention measures are not used but the warning measures are replaced or the offenders have to present themselves to the officers periodically. For those who want to receive treatment and rehabilitation, the Netherlands has demonstrated that a health-based approach can produce a sustained reduction in substance use. The out-of-frame concepts and the organizational improvements have potential for impact. Also, more countries are legalizing marijuana, though under different conditions. Marijuana addiction is not treated as criminal offense. These measures are called the "Decriminalization Policy" meaning addressing addiction as a health issue. In the United States, even though the government uses strict policies to suppress narcotics, some states exempt the offense and allow certain types of narcotic substances to be sold independently. What is more, the drug problem-solving model aimed at universal punishment, strict laws, penalty, and detention poses a serious human rights violation for drug offenders. Further, grouping drug inmates with others in the drug trade only solidifies and expands the drug network.

Based on the lessons from other countries, Thailand should consider the following: 1. Review relevant laws to separate the addicts, the sub-distributors, and the main distributors; 2. Make the punishment proportionate to the offense. The penalty for the offenders must be equal to the committed damage by considering the damage and violence that is caused to the society; 3. Decriminalize use of certain types of narcotics (e.g., marijuana or Mitragynine) and allow these to be used as medically necessary. Thailand has considered decriminalization as part of the latest draft of the Narcotics Act by proposing to allow marijuana to be used for medical purposes, if grown in the areas under control of the Committee on Narcotics Control and the Food and Drug Administration. If the draft becomes law, the Ministry of Public Health will be able to supervise and set up areas for the cultivation and utilization of marijuana; 4. Create alternative measures of punishment, have a policy to divert criminal justice, and choose the process of treatment and rehabilitation of drug addicts; and 5. Focus on clear legal measures for major drug traffickers and networks that damage society by reviewing and amending laws.

Cost comparison of the voluntary system, forced treatment system, and punishment system:

System/Process	Cost/Case (baht)	Cost/visit (person-days)
Voluntary system		
Treatment and rehabilitation process (OPD)	8,366	262
Treatment and rehabilitation process (IPD)	41,419	1,379
Monitoring process (OPD)	1,247	458
Forced treatment system		
Detection process	2,105	788
Process of detention for detection	3,246	138
Non-detained rehabilitation process (OPD)	2,628	615
Non-detained rehabilitation process (IPD)	29,884	447
Detained rehabilitation process (IPD)	65,190	645
Behavior-controlled rehabilitation process (2-month rehabilitation)	2,172	1,170
Monitoring process	3,419	1,532
Punishment system		
Total expenses	19,058	77
Arrest process	900	500
Pass to be detected and proved by the court	1,962	300
Detection	800	400
Pass to the attorney for investigation	2,190	500
Pass the accused to be detained	19,200	8,000

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Key findings and recommendations:

Comparing the public health approach vs criminal justice approach in term of cost

Costs of the voluntary system using treatment and rehabilitation will be significantly lower than the costs in a semi-voluntary system and, especially, the criminal punishment system. In the interim, to maximize the efficiency of budget management, money gained from criminal penalties can be used in funding health programs (e.g., Ending AIDS) or other programs of greater potential benefit. However, a long-term solution is needed since the Thai prison system is nearing the breaking point, mostly because of the incarceration of minor drug-related offenders.

The per capita cost and the full cost to government from past years

Comparison of models and the break-even point
The model without criminal penalty but with action to address AIDS in order to prevent illness and death will be more cost-effective than the current model with criminal penalties and forced treatment of people who inject drugs. The voluntary treatment model will help the government save more budget. Thus, decriminalization should be considered as a policy and plan for case management as the most cost-effective approach to the drug problem.

Obtaining the best return on investment or impact on health, links back to HIV investments and impact on supporting current advocacy towards decriminalization

Impacts from the foreign context arising from the decriminalization.
Some countries (e.g., the Netherlands) have a policy outside the international mainstream, e.g., fully legalizing marijuana. This should lead to an equilibrium of supply in the appropriate approach to drug control. Marijuana addicts are not treated as criminal offenders. This method is called decriminalization, with harm reduction as a treatment method for drug addicts. The outpatient clinic is established as the treatment center or addiction treatment center. The method of control is provided in place for drug addicts in a severe category of up to two years with vocational training as a means of avoiding imprisonment. There is no probation. In the United States, some states agree that the use of excessively strict laws and the emphasis on criminal penalties are not the only ways to reduce the severity of the drug problem. The United States has a broader view and concept of drug abstinence, and as a means of reducing violence by using both control and suppression by using decriminalization. For Portugal, there is no definitive presumption to punish the offenders in drug cases. However, the administrative measures are used instead such as controlling and monitoring the behaviors, requiring reporting to the officers, and forbidding to leave the place at the appointed time, instead of the penalty.

Impacts on Thailand from drug problems.

In Thailand, the situation is still "With more suppression, there is more drug activity". The number of arrests, prosecutions, under trial, and finally-judged cases are in the hundreds of thousands of cases. This reflects Thailand's narcotics suppression policy emphasizing the compulsory sanctions. Thailand has finally reached a point where the prison system cannot cope with this volume of drug offenders. For this reason, Thailand is considering reducing the criminal punishment and use of other measures such as alternative sanctions policies, drug rehabilitation, and even decriminalization. This can provide a chance for drug users to receive treatment in the voluntary system for better longer-term outcomes. It is also necessary to improve the practices and the enforcement of transition from criminal measures to administrative measures by reviewing relevant legislation, tightening the provisions and consolidating them into a single set. Therefore, Thailand should implement the following: 1. Review relevant laws; 2. Make the punishment proportionate to the offense; 3. Decriminalize certain types of narcotics (such as marijuana or Mitragynine) and allow it to be used as medically necessary; 4. Create alternative measures of punishment, have a policy to divert criminal justice and choose the process of treatment and rehabilitation of drug addicts; and 5. Focus on clear legal measures for major drug traffickers and networks that damage society by reviewing and amending laws.

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