Portfolio Overview: Ending Drug Detention

International Harm Reduction Development, Public Health Program

Background

Though the International Harm Reduction Development (IHRD) program began in 1995 to support provision of services like needle exchange and opioid substitution treatment to curb the spread of HIV, by the mid-2000s our primary focus was on changing laws and policies that impeded access to such services. Further, we were aware that the health of people who use drugs was impacted by multiple issues beyond HIV, including interactions with police and prisons. Many international advocates, including UN agencies, hailed it as a great victory when Thailand, Vietnam, China, and Malaysia announced in the first decade of the 2000s that they would treat drug users as patients rather than criminals and increase resources for treatment for those with drug dependence. The annual World Drugs Report of the UN Office on Drugs and Crime (UNODC) reported in 2005 that more than 387,000 people were in treatment in countries that had previously been known best for "zero-tolerance."

People who used drugs in those countries offered a different story. "They called it rehabilitation, but the whole time I was there, I only experienced cruelty," one informant wrote us from China in 2007 to describe a regime of forced labor in total silence for 16 hours a day, beatings for those who "pretended to be sick," and minimal food or medical care. At an international AIDS conference in 2008, NGO leaders from Vietnam, Cambodia, and Malaysia told us privately that anyone whose urine tested positive for illicit drugs was sent to locked "rehabilitation" facilities where they were humiliated, and subjected to brutal physical punishments or arbitrary extension of detention when they spoke back to their "teachers" or attempted escape. Offered the choice between prison and rehabilitation, one drug user who had experienced both told us, "I would definitely choose prison. At least there the guards are trained, and you know the length of your sentence." In China, multiple informants reported swallowing nails or glass to seek a medical exemption from internment for rehabilitation.

Because these drug facilities operated under the banner of treatment and rehabilitation, they avoided scrutiny from UN entities concerned with monitoring penal institutions and received support from those advancing health. UNODC and the World Health Organization (WHO) provided funding for the construction of centers or technical assistance to the staff within them. US-funded implementers of HIV prevention programs, including those with whom IHRD had collaborated, also worked inside the centers, since the high concentration of injecting drug users there offered a simple way of meeting program targets. Former detainees told us that some center directors prominently displayed training certificates bearing the stamp of the US Agency for International Development (two red, white, and blue hands shaking over the slogan, "From the American People") in their offices.

Even allies in the HIV community seemed susceptible to official accounts of "treatment and rehabilitation." Since centers concealed the realities from outsiders (drug users in Vietnam told us about how centers would put meat on plates during visitor tours, but remove it as soon as visitors left the room), most HIV professionals we talked to questioned the reality of accounts of detainees being punished in "discipline rooms," being forced to work without compensation, forcibly HIV tested, or being subjected to experimental research without consent. "That couldn't be happening," one program director in Vietnam told us flatly. "We have staff who have been in those facilities, and have never heard any of that." When pressed, he conceded that he had never asked.

This pattern of rights abuses, the clear barrier to HIV and other health services represented by these detention facilities, and the gap between community experience and official accounts, presented a familiar dilemma to the Public Health Program: how to elevate the accounts of a socially excluded group above the dominant discourse and press for greater protection of their health and rights. To fulfill this mission, it seemed clear that we needed to help tell a different story about drug detention, address policies that forced hundreds of thousands of people who used drugs into harmful institutions, and support a vision for drug treatment that did not include involuntary internment in abusive facilities. Our interest in the issue was also coincident with an emerging focus at PHP on international human rights, including support for the right to health and protection against violations of due process, arbitrary detention, and prohibitions against cruel, inhuman, or degrading treatment.

Portfolio Review Scope

This review explores work on drug detention from 2008—the year that this work crystallized and PHP adopted its 2008-2013 strategy—to the present. While the majority of work considered focused on drug detention in East and Southeast Asia, it also includes a year and half of funding on the issue of compulsory drug treatment in Latin America (grants listed in 2014 and 2015 are those made to date). Appendix A notes the elements in this portfolio, broken down by categories recommended for portfolio reviews by the Strategy Unit.[1]

Animating the 2008-2013 PHP strategy generally, and IHRD work on drug detention in particular, was the belief that human rights advocacy—both in terms of its emphasis on citizen participation, and its focus on the norms and monitoring bodies governing interactions between citizens and state actors—was a powerful lever to improve the health of drug users and other marginalized groups. Specifically, we hypothesized that by shining light on the severe human rights violations occurring in the name of drug rehabilitation and recruiting HIV and human rights experts to join us in that effort, we and local civil society actors could exert pressure on governments to stop abuses in the name of rehabilitation and close centers bringing no health benefit and causing significant human suffering. We deliberately prioritized advocacy over support for services: since governments were already spending monies on these closed institutions, we assumed that they could invest in more effective evidence- and community-based alternatives. Once we learned that activities inside the centers were being supported by international funds, and that this support was being used as endorsement by those running the facilities, we also pressed donors to shift their support to services delivered in voluntary settings. We assumed that this withdrawal of funds would in turn signal to governments that international opinion was against them.

We began work in Asia, where drug detention centers were run by governments, though subsequently turned attention to Latin American countries where facilities are privately run, often by evangelical organizations, with government complicity. As our understanding of the dynamics within the centers (and the limits of our influence) evolved, so did our advocacy targets, which expanded beyond HIV and human rights to include overseas development agencies, labor advocates, and authorities on torture. As our targets changed, so necessarily did our portfolio of grantees and allies.

Public and direct advocacy. As the only international organization working on this issue initially, we had to make the case, even to potential collaborators, that what was being called "treatment" was in fact detention by another name. Together with other OSF entities including OSF-DC and the Communications Department, we began with operational work to document the nature and extent of drug detention, to publicize the problem (both through convenings featuring first-hand and other expert testimony, and the production of publications), and to build allies through private advocacy with the US government and UN agencies concerned with HIV and drug use. Since human rights advocacy at the international level was new to IHRD in 2008, we also engaged some experts to assess the strength of our evidence and claims about rights violations. As our knowledge about the nature of the centers grew, we used our convening and publication power to bring abuses to the attention of relevant authorities outside the HIV and drugs sphere who had not previously engaged. These included human rights monitors concerned with torture and due process—including the Special Rapporteur on Torture, the Committee Against Torture, and the Working Group on Arbitrary Detention—as well as national and international labor advocacy groups, including the International Labor Organization, the US Department of Labor, and the office of the US Trade Representative. On the issue of international funding, we reached out to the US Senate Committee on Foreign Relations, the Global Fund, the US State Department, and the Australian aid program, and briefed members of the European Parliament and members of the UN Commission on Narcotic Drugs. In recent years, we

[1] The Strategy Unit lists possible tools as organizational and/or individual grants; policy and/or public advocacy; litigation; impact investing; government assistance; civil society assistance; and new enterprise development. We understood the term "public advocacy" to include convenings and publications, "policy advocacy" to refer to closed-door meetings with governments or international agencies, and "civil society assistance" to mean technical assistance to grantees.

also engaged directly with representatives of the Vietnamese government, and with those in Brazil, Guatemala and Mexico.

In 2011, PHP launched a collaborative, cross-initiative, time-bound effort, the *Campaign to Stop Torture in Health Care*, to highlight and counteract ways that health settings could be places of abuse or cruel and inhuman treatment rather than care. The work to end drug detention fit nicely with that rubric (other flagship issues included forced sterilization and denial of pain relief), and our efforts on drug detention, including a video, new publications, and engagement with the Special Rapporteur on Torture, received exposure through and some additional PHP funding from the Campaign.

Our total spending on operational work in the portfolio was $418,500, split between public advocacy ($318,500 for convenings at international conferences and production of publications and videos) and policy advocacy ($100,000 to commission expert analysis and to bring partners to meetings with international agencies or government officials). Costs of advocacy by IHRD staff were covered by OSF salaries, and are not broken out here.

Grantmaking. In Asia, drug detention was most entrenched in countries (e.g., China, Vietnam) where constraints on civil society and punishment for public criticism of the government were both severe. Unsure of the extent to which it was safe for national groups (or for us as donors linked to those groups) to engage in public criticism of the drugs response, our grantmaking for the region focused initially on international organizations—particularly Human Rights Watch, in which we invested substantially in project support from 2008-2011, and later, the International Labor Rights Forum (2010-2014)—able to produce credible reports and command media attention and advocacy meetings following their release. In some countries (in Cambodia, and later, in Latin America), local groups felt confident in their own ability to safely document and advocate on the issue of drug detention.

We considered that even if we focused this entire portfolio on one country, IHRD's budget was too limited to sustain service provision at anything close to scale in even the smallest country where we worked. In some countries, however (e.g., Brazil and Vietnam), we decided to support civil society organizations to work with governments to articulate models of harm reduction services that include voluntary, community-based services, and the participation of people who use drugs. The elements that made these countries most suitable were clearer in retrospect (see Lessons, below), but we selected Vietnam and Brazil because both were countries of international and regional influence, both had been leaders in the delivery of HIV services and received international attention for their reforms in that arena, and because in both policy responses to drugs were commanding public and Parliamentary attention.

Since 2008, our grantmaking in the portfolio has totaled $1.41 million, almost evenly split between international and national/ local groups.

Civil society assistance. When openings for reform have emerged, civil society groups have turned to us for technical assistance in order to provide help in turn to governments in devising rights-based, effective alternatives. We engaged international experts to provide technical assistance on drug treatment and community-based, harm reduction housing in Vietnam and in Brazil, and supported internships or other professional development opportunities for key staff at NGOs acting at the interface between government and communities of people who use drugs. This has totaled $166,000.

Reflecting on our Impact

Appendix C provides a detailed chronology of OSF/grantee activities and outcomes during the period under review. Generally, it is clear that international discourse on drug detention has vastly changed since we held our first convening on the issue in 2008. The heads of twelve UN agencies have signed a public call for closure of drug detention centers. OSF is no longer the primary public advocate on the issue, which has been taken up by multiple rights defenders and NGOs. When we began, the US, Australia, UNODC, and the Global Fund supported Asian drug detention centers with little scrutiny. Today all have ceased or severely limited support, instead directing funds to

services delivered in community settings or restricting services to lifesaving medical interventions delivered by external staff.

As late as 2012, international labor organizations and the US government refused to acknowledge that forced labor was an issue in drug detention centers, or denied that products in those centers were being produced for export. Today, American apparel and footwear manufacturers have warned the Vietnamese about the phenomenon, the International Labor Organization and the US Trade Representative have expressed concern, and the US embassy identifies an end to forced labor in drug detention centers as among their top human rights priorities in Vietnam.

Changes in Geneva or Washington do not necessarily mean anything in Hanoi or Kuala Lumpur, but there are also significantly fewer people in detention centers than when we began this work. Progress has been most marked in Vietnam, where there were an estimated 100,000 detained in 2008. Today, that number is around 23,000, and the government has committed to reduce that further to 10,000 by 2020. When we began, detention in Vietnam was triggered by a positive urine test, with quotas for numbers of detainees delivered by the government and fulfilled by neighborhood committees. Today, there is a court process and medical evaluation required for all detainees. The "bad cop" (Human Rights Watch), "good cop" (our NGO grantee on the ground in Vietnam, called SCDI) strategy appears to have worked, with the government agency in charge of responding to drug use, the Department of Social Evils Prevention, now engaging publicly both with SCDI and with drug user groups. In five provinces, substantial (though still insufficient) government resources have been committed to adopting a voluntary, community-based approach, including construction of new facilities, and all provinces have been requested to come up with community-based alternatives.

Malaysia, where we and partners engaged in public and policy advocacy, has also moved to replace large numbers of its compulsory centers with voluntary facilities that have offered a range of drug dependence services to more than 36,000 people since 2010. Brazil, which began with proposals to "strike hard" at and intern crack users in compulsory treatment centers, is now piloting "Project Open Arms," a São Paolo, community-based model that offers housing and employment even to those actively using crack. While formal evaluation is still pending (with OSF support), preliminary results are promising, and the federal government this year announced expansion of the "open arms" model to 21 additional cities.

These successes are neither complete (the possibility for involuntary internment for drug use still exists in all countries) nor universal. In Laos, we were unsuccessful in getting any government response or any organization willing to champion change. In Cambodia, closure of the most notorious center did not result in longstanding reduction of numbers detained, as a new women's facility opened elsewhere shortly afterward. The group that we supported to document rights abuses there provoked government reprisal, rather than increased collaboration, with Cambodian police surrounding their drop-in center for two days and demanding that program participants use an experimental, herbal cure for addiction or face immediate imprisonment. Intervention by armed staff from the US Embassy's anticrime unit ended that standoff, but the government soon found less direct ways of harassing the organization, revoking their needle exchange permit and, eventually, forcing departure of their American executive director from the country. In China, a 2011 law passed to limit the work day in drug detention centers to six hours—already grossly insufficient to address the wholesale and arbitrary detention of more than a hundred thousand drug users with no medical evaluation—remains largely unenforced. The local government is working with our grantee in one prefecture to pilot a promising alternative to drug detention. The overall system remains largely unchanged.

The shifting frame of advocacy on drug detention

Those successes that we and partners did achieve required us to reframe our advocacy objectives, messages and alliances significantly to meet new challenges. As in an arcade game, where each target downed is replaced by a new one, each milestone achieved in this portfolio revealed other obstacles (and opportunities). Perhaps the single greatest lesson of this work has been the importance of changing levers as our understanding of the context changed. Some examples:

From challenging official government accounts to the ethics of international assistance. Reports and other advocacy by PHP and our grantees—including photographic evidence and powerful first-hand testimony—succeeded in challenging the claims by governments that they were treating drug users "like patients" in Asia, and have begun to do the same in Latin America. This proved a powerful corrective to the argument that naming drug use as a "health rather than criminal issue," is an end in itself. We, however, sought closure of the centers and respect for the rights of drug users as well as to correct the public account, and here our assumption that revealing the abuses would persuade international actors (mostly including UN agencies such as UNICEF and contractors of USAID) to disengage from the centers and in turn exert pressure on Asian governments proved incorrect. USAID contractors felt uncomfortable criticizing government officials, since their contracts also included work with government outside the centers. Further, some large HIV implementers argued at first that it would be unethical to cease HIV prevention efforts within the centers, instead proposing that their work—primarily educational workshops—was humanitarian in nature. Health officials within the US government, which supported delivery of some HIV medications in the centers, also claimed their effort was humanitarian.

Here an unanticipated ethical dilemma—as well as a new advocacy opportunity—presented itself. To refine our government advocacy and explore the question of when, how and by whom legitimate health assistance can be delivered in illegitimate institutions, we commissioned a report by ethicists from the Hastings Center, a NY-based health ethics group with a long history of examining thorny public health issues. The report raised the possibility that international engagement in drug detention centers constituted what political scientist Avishai Margolit called a "rotten compromise"[2]— an agreement, however well intentioned, that bolsters a political order based on systematic cruelty and humiliation. Along with OSI-DC, we convened US government officials and large project implementers together with groups like MSF and the International Red Cross to further insights about how these experienced humanitarian actors delivered medical services in illegitimate settings. The practical suggestions produced at this meeting (e.g., focus on urgent or lifesaving services, require that visits with detainees can be conducted without officials of the institution present; agree in advance that no organizational logos are used or public announcements are made to suggest that the international presence implied endorsement; require ability to visit without prior permission, articulate clear redress mechanisms for cruel or inhumane conditions such as chaining and beating; etc.) helped clarify the skills HIV programmers needed to prevent being used to endorse or sustain systemic cruelty—and highlighted US implementers' lack of capacity to realize such safeguards. With the exception of provision of lifesaving HIV medicines funded by the US government, administered by outside medical staff to some center detainees in Vietnam, donors like Australia, the Global Fund, UNODC, and UNICEF who supported work in the drug detention centers do so no longer. HIV programmers have continued to provide some services outside the centers, and provision of HIV medicines previously covered by the Global Fund have since been provided by the Vietnamese government. We consequently judge the benefits or our approach to outweigh any humanitarian consequences.

From health rights to labor advocacy. We originally viewed drug detention through a health rights lens—assuming that the lack of HIV treatment in the centers, the total lack of efficacy of the facilities (rates of relapse to drug use from the centers approach 100%), and the offer of cheaper and better approaches such as provision of methadone would spark change. In China and Vietnam, however, it took several years and first-hand exchanges with former detainees before we understood the centrality of local labor contracts, and the limited incentives for central government officials (themselves often unfamiliar with the actual workings of the centers) to change the drug detention model. Most centers (except the show facilities designated for foreign visitors) were profit-making enterprises, with center directors contracting with private companies and using detainees as free labor to manufacture clothing, process cashews, or make footballs and other goods. When we realized the international health agencies and representatives of health ministries we had rallied to the cause had little influence on either buyers or sellers, we had to try a different lever—advocacy on trade. We worked with the International Labor Rights Forum, who used smuggled accounts from center detainees in Vietnam to update work done by HRW, and recruit allies from the labor movement to express concern about worker exploitation. While it is too simple to attribute any single cause for policy change, well-placed sources in Vietnam suggest that it was the recurrence of

[2] For more on rotten compromises and drug detention, see Saucier, R., Berlinger, N., Thomson, N., Gusmano, M., Wolfe, D. (2010). The limits of equivalence: Ethical dilemmas in providing care in drug detention centers. *International Journal of Prisoner Health 6(2)*:81-87.

the issue of drug detention in the labor sphere that startled the government to action. Work by grantees resulted in receipt of formal complaints from the American Apparel and Footwear Association (see Appendix D), an HRW report implicating the $1 billion Vietnamese cashew export industry in slave labor, mention of Vietnamese garments in the US State Department's Trafficking in Persons report, formal mention of forced labor in drug detention by the ILO, and attention to the issue of drug detention by the US Trade Representative negotiating with Vietnam on the Trans-Pacific Partnership trade agreement.

From single issue to coalition. As noted above, in 2011, PHP launched the *Campaign to Stop Torture in Health Care* as a way to connect work that showed health care settings as sites of abuse rather than healing, and to work toward collective solutions. Under the auspices of the Campaign, we produced a new report of firsthand accounts of abuses—this time expanding beyond Asia to include stories from Russia and Mexico. A main benefit of the combined Campaign was the opportunity to present work, jointly with disability rights advocates and those working to increase access to pain relief—to the Special Rapporteur on Torture, Argentinian national Juan Mendez. Mendez's subsequent thematic report, and a companion volume to that report in which he solicited a chapter on the question of government culpability for abuses in private centers, helped us open discussion of two areas new to us: privately operated centers and drug detention practices in Latin America. This work also helped us to make important links to other groups, such as the disability rights community, whose advocacy against forced institutionalization (including with OSF support) in Latin America was more developed and included aspects of relevance to people who use drugs.

Six lessons

Review of this portfolio offers three initial lessons related to outcomes, two on process, and one overarching lesson.

Lessons on outcomes

1. **Country incentives/partners**

As we reflect on work in Asia and develop a drug detention portfolio in Latin America, it seems important to try to identify the incentives or conditions that increase likelihood of country impact. Why was drug detention work more successful in Vietnam than in Cambodia, China, and Laos? What has given our work in Brazil traction while our grants in Guatemala have had less?

a. *Mutual international interest.* Vietnam, for example, intersected at multiple points with relevant foreign governments with a stake in the drug detention discussion. The country received significant support from the US and the Global Fund for AIDS, Tuberculosis and Malaria, and was engaged in multiple trade and economic exchanges (e.g., Trans-Pacific Partnership Agreement) outside the HIV sphere. Vietnam relied heavily on exports to Australia and the US, governments to which we and partners also had connections. Cambodia and Laos, by contrast, were less important economically, received less aid, and seemed more concerned with their image in the region than outside. China was too big to worry about either international aid (indeed they have become a donor) or to feel threatened by the US on trade.

b. *Domestic resources.* While community-based services to address drug dependence may be cheaper than institutions, funds are not necessarily fungible. Without some resources to put into the mix, governments are unlikely to be able to transition from existing systems, however punitive. Guatemala's total budget for drug treatment is smaller than IHRD's own; Laos has extremely limited funds. Brazil and Vietnam, by contrast, have been able to rally some resources of their own to the discussion, deepening their professional as well as financial investment in success.

c. *NGO partners able to negotiate inside/outside dynamics with the government.* The existence—in Vietnam and Brazil—of NGOs with sophistication to both relay information to help critique drug detention and to offer support to governments on solutions, has proved critical. Playing this inside/outside role requires deftness at knowing when to be critical friend and when to get others to do so: in Cambodia, for example,

our grantee offered only criticism, and government pushback severely hampered the organization's ability to work even outside the sphere of rights advocacy. In Laos, as in Guatemala, there seem to be few civil society partners able to work effectively on drug detention.

2. Human rights documentation essential; international mechanisms more dependent on context

When we began, multiple actors (including UN agencies, implementing organizations, and US government representatives) expressed concern about human rights documentation in Vietnam, saying it was culturally inappropriate, and an overly blunt instrument that would make the government more intransigent. While some of those individuals have rotated out, staff in those same agencies now frequently reference the Human Rights Watch report as critical to changing the conversation, though not necessarily for the reasons anticipated. Searing criticism from outside may have made indigenous advocates seem "reasonable" to the government in comparison—and created space for NGOs to act as a helpful, if critical, local friend.

As for engagement with international treaty bodies and special procedures, their impact may be more region-specific. In Asia, criticism by the Special Rapporteur on Health and comments from the Committee on the Rights of the Child did receive some media coverage—and reinforced messages coming from non-governmental rights advocates. In Latin America, the critiques of both the Special Rapporteur on Torture and the Working Group on Arbitrary Detention (Brazil) have had resonance.

3. Criticism without support for solutions is insufficient; technical assistance to articulate alternatives is essential

We began convinced that it was not the role of OSF or grantees to fund services or assist governments—WHO or UNODC could do that, while they would never support naming or shaming. The need for alternatives also seemed like a tactic for delay: we maintained that drug detention centers should be closed down and people released immediately, since nothing would often be better than the status quo (many of those held in drug detention centers, placed there only on the basis of a single urine test, do not need treatment at all). Our limited resources and overall human rights profile also convinced us that funding alternatives was not our appropriate niche.

In retrospect, however, it has proved key to at least offer civil society groups assistance and to have them, in turn, offer the government assistance in building voluntary and community-based treatment systems. Our funding is more flexible than that of city or federal government; while we maintain we cannot afford to pay for services themselves, we can support the introduction of new concepts and shape the evaluation of them. Foreign experts can offer insights that would be difficult to receive from those embedded in existing systems; as long as local organizations can help to broker, this has proved useful. Indeed, support for solutions has also proved critical to the legitimacy of our civil society partners in the eyes of their government. If we are only bringing criticism to the table, that is not enough.

<u>Lessons on process</u>

4. Unintended consequences of general operating support

In 2011, when HRW secured long-term, general support from the OSF President's office, an unintended consequence was the loss of our most influential and knowledgeable ally in this work. HRW's Health and Human Rights Division had developed extensive contacts, knowledge, and credibility in the fight against drug detention. Headed by an epidemiologist PhD, the division also brought credibility in public health circles and peer-reviewed journals, and HRW's communications and multimedia efforts greatly amplified the impact of their work. Though division staff remained personally invested in the issue, HRW's revenue model compelled them to move on to other topics for which they could fundraise. Their lead researcher on drug detention was obliged to work on environmental justice. We felt the loss of this alliance acutely. In retrospect, we would have sought an exemption to the request that no thematic programs fund the group on a project basis following receipt of a large, general support grant.

5. OSF public advocacy was of greatest value when field was new

While we spent significant resources ($318,500) convening experts and producing publications to call attention to the drug detention problem, events and publications were not equally influential, and their influence did not increase with cost. Rather, impact of our public advocacy was greatest when little had yet been written about the issue, and when OSF's reach and ability to elevate the voices of drug users without fear of antagonizing an external funder made us particularly well positioned to help build the field. Later, as noted, HRW and other partners like ILRF were well placed to do subsequent documentation and amplify report findings in the media or with key allies (e.g., labor advocates) we did not know. Documentation by others also made it seem that it was not just OSF that was concerned about the problem; instead, concern appeared to be bubbling up organically from multiple sources. Once we were established as an authority on the issue, it was tempting to keep publishing, rather than to recognize that we added most value at the start and could have relied on grantmaking to sustain the work. Participation in the collaborative campaign on torture also produced incentives to brand and produce materials as part of that effort, perhaps independent of the genuine need for such materials to be created by OSF at that time. The ideal arc is somewhat similar to a relay race – we start off with the baton ourselves, run with our partners for a short time, and then hand off the baton. In this instance (as with some of the publications produced after 2010), we kept running a little longer than was useful or necessary.

Overall lesson

6. Advocacy grantmaking

Taken together, these lessons suggest a more general approach to grantmaking to civil society on volatile issues: help frame the question; fund the most strategically agile local groups; make them look reasonable by supporting international groups to name and shame; and provide those local groups with TA to increase their legitimacy and with some funds to in turn provide expertise to governments and secure a role in reform.

Conclusion

Despite its limits, this work on drug detention has been some of the most compelling and important undertaken by IHRD, and of which we are most proud. A previously unremarked pattern of abuses against people who use drugs has been revealed and curtailed. Governments and UN agencies can less easily pretend that calling something treatment means that it is necessarily less punitive, coercive, or counterproductive than other drug war interventions. NGOs working with people previously considered morally suspect or irrelevant now participate in the shaping of community-based services that impact them, including in countries where NGO involvement is often anathema. Human rights advocates who regarded neither health nor drug use as domains of interest have become engaged partners. And in Asia, there are 100,000 fewer people who use drugs in detention.

Building on promising initial work, we look forward to meeting the challenge of effecting a similar change in public discourse and health practice in Latin America. There, it is likely that we will need to engage faith leaders, rather than labor advocates, for new leverage. We are confident that the lessons of past work in Asia—including identification of the best countries and NGO partners for deeper investment, and of finding new allies or arguments as the political landscape becomes clearer—remain relevant. We look forward to reviewing, some years from now, the portfolio of OSF work on drug detention in that region that made profound change possible.