GLOBAL COMMISSION ON DRUG POLICY

THE WORLD DRUG PERCEPTION PROBLEM

Countering prejudices about people who use drugs

2017 REPORT PRESS KIT

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KEY FINDINGS

1/ THE PERCEPTIONS OF PEOPLE WHO USE DRUGS FORM A VICIOUS CYCLE

Negative portrayals in politics and the media reinforce the perception that drug use is immoral and people who use drugs are a threat to society. This increases the stigma of and discrimination against people who use drugs. and leads the public to believe that drugs are illegal for a good reason. This, in turn, enables discrimination towards people who use drugs, which often means that they are considered as undeserving of the same rights, for instance the right to health, as other citizens; they are marginalized and seen as sub-human, non-citizens, and scapegoats for wider societal problems.

- *No medical condition is more stigmatized than "addiction."*
  Even trained mental health professionals who were given identical case studies - but where in one the patient was referred to as "a substance abuser", and in the other as "someone with a substance use disorder" - were more likely to believe that the patient in question was personally culpable and that punitive measures should be taken when the term "abuser" was used.
- *Moral panics: example crack in the US in the 80/90s*
  Several key misconceptions were promoted: that crack was uniquely addictive; that its use was exploding; and that pregnant women consuming crack would produce a generation of "crack babies," who would be severely emotionally, mentally, and physically disabled and grow up to be "super-predators." Election campaigns focused on fighting crack and being "tough on drugs" and in the election years, these were ranked by the public as important social issues, but tellingly in the years when there were no elections, drugs were not rated as such an important issue. Scientific surveys, however, showed that the overall use of cocaine had not risen but fallen, and that the vast majority of users reported snorting cocaine rather than smoking it – meaning they were using powder cocaine, not crack. There were no "crack babies" to be found. Instead of the expected disabilities, it is now thought that cocaine use during pregnancy has a similar effect as tobacco and a less severe effect than alcohol use.
- *Change is possible*
  In Portugal, a coalition of political leaders decided over 15 years ago to set up a scientific panel to make evidence-based recommendations for dealing with the country's drug problems. Those recommendations were implemented, and the situation in the country has improved dramatically on indicators such as death from overdose etc. In Switzerland's direct democracy, drug policy reform has repeatedly triumphed at the ballot box. Most believe this is because the public was well informed of the facts and improvements brought about by harm reduction measures and heroin-assisted treatment.

2/ THE LEGAL STATUS OF A DRUG RARELY CORRESPONDS TO THE POTENTIAL HARMS OF THAT DRUG (I.E. IT IS NOT BASED ON EVIDENCE)

- Little or no correlation has been found between the UN scheduling of substances as "most dangerous", "moderate risk" and "low risk" and their harms as assessed by the Lancet landmark study published in 2007. When taking into account not only the risk to the individual but to society as well, alcohol ranks as more harmful than heroin.
- The potential harms of a substance are increased when it is produced, obtained and consumed illegally: currently taking street heroin poses the greatest risks to an individual but the use of medical grade heroin eliminates a great number of those risks and people can live normal lives while receiving this treatment.

3/ THE MOST COMMON PATTERN OF DRUG USE IS EPISODIC AND NON-PROBLEMATIC

- An estimated quarter of a billion people (aged 15-64) currently use illegal drugs, of which about 11.6% are considered to suffer problematic drug use.
- 'Lifetime use' figures (individuals who have taken a certain drug at least once in their life) are much higher than figures for 'use in the past year' for all substances. In the EU, cannabis: 87.7 million vs. 23.5 million; cocaine: 17.5 million vs. 3.5 million; MDMA (ecstasy): 14.0 million vs. 2.7 million; amphetamines: 12.5 million vs. 1.8 million. This indicates that most people who try a drug do not become dependent or frequent users.
- Estimates of addiction rates (out of those who try a drug, how many will become addicted) are 23% for heroin, 17% for cocaine, 15% for methamphetamine, 9% for cannabis; for tobacco, the rate is 32% and for alcohol, 15%.

4/ FOR THOSE WITH PROBLEMATIC USE, A LARGE RANGE OF OPTIONS IS NEEDED TO PROVIDE THE APPROPRIATE TREATMENT FOR EACH PERSON WITH PROBLEMATIC DRUG USE

The range of treatments should include psychosocial support, substitution therapy, heroin-assisted treatment; not only abstinence. There is strong evidence for the effectiveness of these treatments.

- Only one in six individuals with problematic drug use receives treatment.

5/ WHAT SHOULD BE FACTUAL DISCUSSIONS ARE FREQUENTLY DEBATED AS MORAL ONES

Current policies and responses are often based on perceptions and passionate beliefs, not evidence.

- **It is not true, for example, that only people on the margins of society use drugs**. Even those frequenting the infamous "needle park" in Zurich, one of the biggest open drugs scenes in Europe in the 1980s and 1990s, did not conform to that stereotype. When researchers conducted interviews, they found that almost half of those interviewed (49.1%) attended work or school regularly and lived in an "orderly fashion," either in their own apartment or sharing with friends. Only 1 in 5 of those interviewed did not have a job, and lived in a shelter or were homeless.

EXECUTIVE SUMMARY

Previous reports by the Global Commission on Drug Policy have shown how the potential harms of drugs for people and communities are exacerbated by repressive drug control policies at local, national and international levels. The present report, while fully acknowledging the negative impact that problematic drug use often has on people's lives, focuses on how current perceptions of drugs and people who use them feed into and off prohibitionist policies.

Indeed, drug policy reforms have sometimes been difficult to carry out, design or implement because current policies and responses are often based on perceptions and passionate beliefs, and what should be factual discussions – such as the efficiency of harm reduction – are frequently treated as moral debates. The present report aims to analyze the most common perceptions and fears, contrast them with available evidence on drugs and the people who use them, and on that basis recommend changes that can be enacted to support reforms towards more effective drug policies.

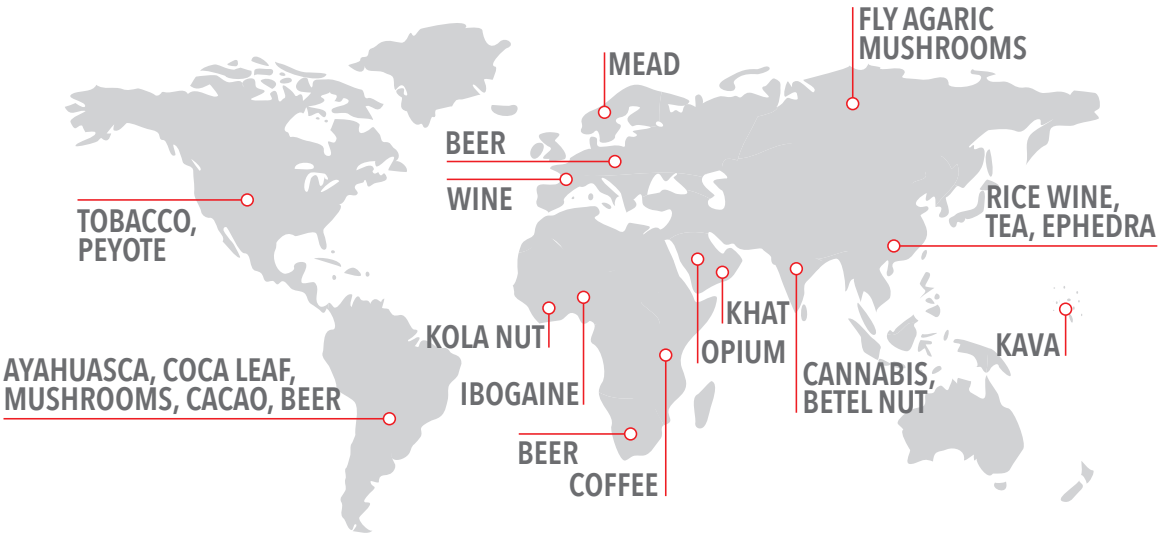
WHAT IS A DRUG?

In the broadest sense, a drug is any substance that has an effect on either mind or body. However, for substances that act on the mind (psychoactive), the term drug has acquired a negative meaning. In the pharmacological sense, caffeine, nicotine and alcohol are drugs just as cocaine and heroin are.

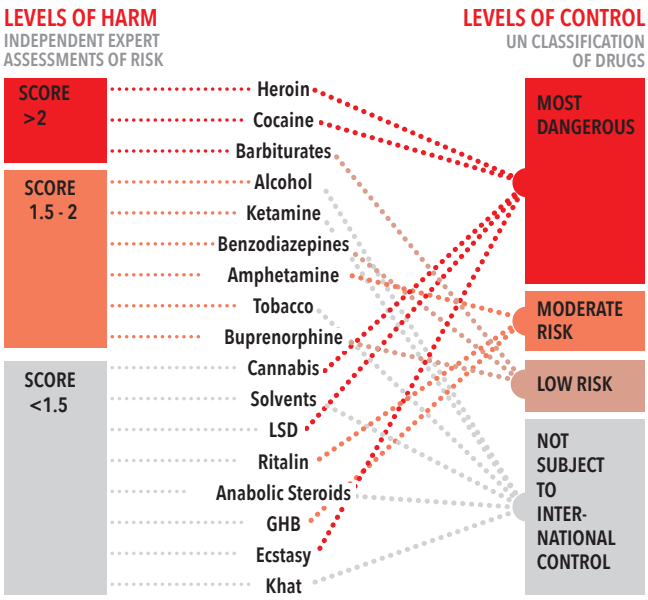
Drugs, addiction, and the aim of treatment

Drugs are often presented as unnatural contaminants, pushed into a society from the outside or by deviant forces, and many people fear them. In reality, taking substances to alter one's mind seems to be a universal impulse, seen in almost all cultures around the world and across history (though the substances that are used vary). Furthermore, while there are certainly risks involved in all drug use, the legal status of a drug rarely corresponds to the potential harms of that drug. In addition, the potential harms of a substance are increased when it is produced, obtained and consumed illegally.

TRADITIONAL DRUG USE AROUND THE WORLD



CLASSIFICATION OF DRUGS



It is also widely believed that drug addiction is the result of someone simply taking a drug casually for pleasure, then becoming accidentally "hooked" on the chemical substances within the drug and thereafter "enslaved". However, this is based on a misunderstanding of addiction. Drug use is relatively common and, in 2016, an estimated quarter of a billion people used currently illegal drugs, while about 11.6% of these are considered to suffer problematic drug use or addiction. The most common pattern of use of psychoactive substances is episodic and non-problematic.

Addiction is often believed to be permanent and irreversible. If recovery is deemed possible, abstinence is generally perceived as the primary – and often only – goal of treatment. However, the primary goal of treatment should be to allow a person to attain, as far as possible, physical and mental health. From this perspective, abstinence is not necessarily the best objective for treatment for a particular person, nor even perhaps his or her aim. Even when it is, many people with problematic drug use only achieve abstinence after several attempts.

A large range of options is therefore needed to allow for doctors and their patients to freely decide on the appropriate treatment. Options include psychosocial support, substitution therapy, and heroin-assisted treatment. There is strong evidence for the effectiveness of these treatments.
In addition, many scientifically proven methods prevent much of the harm caused by drug use – foremost those caused by failed repressive policies – without aiming for abstinence: harm reduction interventions, such as needle and syringe programs, safe injection facilities, provision of opioid-overdose antagonists, and drug checking.

Perceptions surrounding people who use drugs

When considering the reasons why someone might take drugs, psychological and moral explanations generally prevail, primarily the assumption that the person is "weak" or "immoral". Thus, the general public often sees problematic drug use as an individual problem and not one that society needs to deal with. Another common stereotype of people who use drugs is that of people living on the margins of society, who are not equal members of it or entitled to the same rights as others.

These perceptions and stereotypes contrast with what experts consider to be the primary reasons for consuming drugs. These include youthful experimentation, pursuit of pleasure, socializing, enhancing performance, and self-medication to manage moods and physical pain.

Another widespread perception is that people who use drugs, and particularly people with problematic drug use, engage in criminal activities. But the vast majority of those who use drugs are not committing any crime other than the contravention of drug laws. Individuals with problematic drug use often cannot afford the drugs they need without resorting to crime themselves. In addition, people who use drugs are often forced out of the mainstream and into marginalized subcultures where crime is rife. Once they have a criminal record, they find it much harder to find employment, thus making the illegal market and criminal activity one of their only means of survival.

Portrayals in the media and among the general public

The perceptions discussed in the report are largely influenced by the media, which portray the effects of drugs as overwhelmingly negative. Two narratives of drugs and people who use them have been dominant: one links drugs and crime, the other suggests that the devastating consequences of drug use on an individual are inevitable.

Public opinion and media portrayals reinforce one another, and they contribute to and perpetuate the stigma associated with drugs and drug use. Commonly encountered terms such as "junkie", "drug abuser" and "crackhead" are alienating, and designate people who use drugs as "others" – morally flawed and inferior individuals.

Such stigma and discrimination, combined with the criminalization of drug use, are directly related to the violation of the human rights of people who use drugs in many countries. Therefore, in order to change how drug consumption is considered and how people who use drugs are treated, we need to shift our perceptions, and the first step is to change how we speak.

Queen Elizabeth II is offered a drink of Kava during a visit to Fiji.
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The link between perceptions of drugs, those who use them, and drug control policies

The link between the perception of drugs, the people who use them, and drug policy constitutes a vicious cycle. Under a prohibitionist regime, a person who uses drugs is engaging in an act that is illegal, which increases stigma. This makes it even easier to discriminate against people who use drugs, and enables policies which treat people who use drugs as sub-human, non-citizens, and scapegoats for wider societal problems.

DRUG USE OVER TIME

Of the world population aged 15-64, only 0.6% exhibits problematic drug use.

This represents 11.57% of all people who use drugs (age 15-64).

Another fact that belies the assumption that drug use inevitably leads to addiction is that. in 2004, 9% of all adults in Europe age 15-34 declared having consumed drugs in the past year; 13 years later, only 3.4% of the same group (now aged 25-44 years old) had used drugs in the past year.

NUMBER OF PEOPLE WHO RECEIVE TREATMENT FOR PROBLEMATIC DRUG USE

Each year, only 1 in 6 people globally who need treatment actually access it: 1 in 18 in Africa (mainly cannabis); 1 in 5 in Western & Central Europe; 1 in 4 in Oceania; 1 in 3 in North America. (UNODC 2014).

In the US in 2014, only 18% of the 22.5 million people requiring treatment for drugs (alcohol included) were receiving it, compared to 77% for hypertension, 73% for diabetes, 71% for major depression.

First, the fear of drugs has translated into messages for prevention that promote complete abstinence and state that all drugs are equally bad. However, providing information which is incomplete and often even incorrect lessens any chance of trust between the authorities and young people.

Second, drug use is perceived as a moral issue, considered a public wrong, and is therefore criminalized, even though drug consumption itself is a non-violent act, and poses potential physical harm only to the person who engages in it. Yet in many countries the death penalty is applied to some non-violent drug offenses, placing them de facto on a similar moral ground to murder and other most serious crimes.

VICIOUS CYCLE OF PERCEPTIONS OF PEOPLE WHO USE DRUGS

RECOMMENDATIONS

Recommendation 1

Policy makers must aim to change current perceptions of drugs and people who use them by providing reliable and consistent information.

Good leadership strives to influence public opinion for the better. Political leaders are instrumental in shaping what the public believes, and have a moral responsibility to provide evidence-based and accurate information. Leaders must be bold when disputing perceptions about drugs which are not grounded in facts and which may be discriminatory towards people who use drugs, and stand their ground in the face of public opinion. When political leaders choose to stoke fears about drugs and drug use in order to retain or intensify prohibition, they are indirectly causing serious hardship to some of their most vulnerable citizens. When political leaders instead choose to challenge some of the current perceptions about drugs and people who use them, they can make a real difference. In the last two decades, principled actions from some political leaders in Europe and Latin America have already led to changes in attitudes towards drug control which have in turn led to harm reduction, decriminalization and regulation becoming public policy, and to improvements in public health in their countries.

Recommendation 2

Opinion leaders must live up to their responsibility in shaping public opinions and perceptions on drugs, and promote the use of non-stigmatizing and non-discriminatory language.

Media, religious leaders, intellectuals, celebrities and other influencers have the potential to be powerful allies in correcting misinformation surrounding drug use and reducing the stigma towards people who use drugs. In particular, the use of degrading and inappropriate language – such as "junkies," "zombies," and "fix rooms" – should be addressed and corrected. They must restrain from further propagating misinformed beliefs which can potentially result in disastrous situations for people who use drugs, their communities, and the most vulnerable parts of society.

☑ USE	☒ DON'T USE
Person who uses drugs	Drug user
Person with non-problematic drug use	Recreational, casual, or experimental users
Person with drug dependence, person with problematic drug use, person with substance use disorder; person who uses drugs (when use is not problematic)	Addict; drug/substance abuser; junkie; dope head, pothead, smack head, crackhead etc.; druggie; stoner
Substance use disorder; problematic drug use	Drug habit
Has a X use disorder	Addicted to X
Abstinent; person who has stopped using drugs	Clean
Actively uses drugs; positive for substance use	Dirty (as in "dirty screen")
Respond, program, address, manage	Fight, counter, combat drugs and other combatant language
Safe consumption facility	Fix rooms
Person in recovery, person in long-term recovery	Former addicts; reformed addict
Person who injects drugs	Injecting drug user
Opioid substitution therapy	Opioid replacement therapy

Recommendation 3

Take part in the debate, sustain activism and advocacy, and keep governments, parliaments, the judiciary, mayors, media, healthcare and social professionals accountable.

Ordinary citizens have the capacity to transform this debate. Activism must be sustained, to develop the ability of civil society to hold governments, the media and other stakeholders accountable. The creation of national and regional networks of people who use drugs must be promoted to enable them to stand up effectively for their rights in every community. Other civil society actors in the areas of human rights, infectious diseases, criminal justice and non-communicable diseases need to come together to overturn the negative perceptions in society and reduce stigma, as well as denounce current drug policies and promote evidence-based reforms to the law.

Recommendation 4

Stop acts of harassment based on negative perceptions of people who use drugs.

Law-enforcement agents must stop acts of harassment against people who use drugs, such as intimidation, unwarranted searches, unwarranted seizure of property and racial profiling. Instead they should focus on the social role of law enforcement by directing them towards health and social services if they need it, and simply issue warnings for those who do not experience problematic drug use but have disturbed public order by using drugs in the public sphere. The judiciary system must consider drug dependence or problematic drug use as a mitigating factor in sentencing petty crime cases, instead of considering them as an aggravating factor. Incarcerating people that need medical and social support only exacerbates social ills and does not prevent them. Law enforcement plays a central role in the general population's perception of people who use drugs. In collaboration with other drug policy stakeholders, they can address the perception-based character of criminalization and ensure the rule of law.

Recommendation 5

Putting health and safety first requires the medical community and healthcare professionals to be vocal in promoting evidence-based prevention, treatment, and harm reduction services, and to urgently address perception-based stigma in healthcare settings.

Doctors, nurses, and other healthcare workers who are in contact with people who use drugs have a major role to play in changing the perceptions on drugs. They are often the first point of contact with people who use drugs, and can be influential in feeding evidence back to the public. As they are in a position of trust, they must play an important advocacy role in improving the provision of services for people with problematic drug use. In particular, experienced healthcare professionals must be vocal in defending the usefulness of treatments that have proven effective – by speaking up in support of opioid substitution treatment, for example, which is still stigmatized by large portions of society.

Recommendation 6

Take advantage of the opportunity presented by the upcoming UN Commission on Narcotic Drugs' Ministerial Segment in 2019 to review the use of language in international documents and in negotiations.

Member States must review their use of language and their prejudices while negotiating international political agreements on drug control. The UN Secretary-General must ensure the UN system provides a consistent, people-centered language when addressing drugs, in line with the sustainable development agenda. UN entities must continue providing evidence-based publications and panels in order to inform diplomats, policy makers and citizens the world over on the facts and aim to change existing perceptions. To date, the UN political declarations and plans of action on drug policy have perpetuated demeaning and harmful language, referring to people as "drug users," and calling to "counter" and "fight" drugs. They also failed to include services that provide evidence-based tertiary prevention and risk mitigation, such as "harm reduction." Meanwhile, other international mechanisms have made more progress in providing better language and descriptions of drugs and people who use them. Those texts were for the most part not negotiated by Member States, but rather produced by UN entities such as specialized agencies, Funds and Programs.

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BIOGRAPHIES OF COMMISSIONERS PRESENTING 2017 REPORT

Ruth Dreifuss

Chair of the Global Commission on Drug Policy
Former President of Switzerland

Ruth Dreifuss (born in 1940, single) studied in Geneva, where she received a degree in economics with special focus on econometrics in 1971. In her varied professional career she served as hotel secretary, editor of the weekly journal Coopération, social worker, and assistant at the Geneva University. She then worked nine years for the Swiss Agency for Development and Humanitarian Aid (Federal Department of Foreign Affairs) and became in 1981 Secretary of the Swiss Labour Union Federation. In that capacity, she was responsible for sectors including social insurance, labour law, gender equality and relations with the International Labour Organizatio Organization (ILO).

Ruth Dreifuss was elected Federal Councillor (Member of the Swiss government) in 1993 by the Federal Assembly (Parliament), and was re-elected twice. From 1993 to her resignation in 2002 she was Head of the Federal Department of Home Affairs, the ministry responsible for public health, social insurance, scientific research, higher education, gender equality and culture, as well as the environment until 1997. During the year 1999, Ruth Dreifuss was President of the Swiss Confederation.

As the Federal Councillor in charge of public health and social insurance, she implemented a new policy in the fields of drug addiction and prevention of HIV/AIDS. She also oversaw the introduction of the new law on health insurance, which guarantees universal coverage for the Swiss population. After her retirement from government, she chaired the commission mandated by WHO that reported on public health, innovation and intellectual property rights, and co-chaired the High Level Panel on the same subject, which was mandated by the United Nations Secretary-General. Ruth Dreifuss currently serves as a member of the International Commission Against the Death Penalty.

Ruth Dreifuss is Doctor *honoris causa* of the Universities of Haifa, Jerusalem and Fribourg (Switzerland).

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Olusegun Obasanjo

Former President of Nigeria, Chairman of the West Africa Commission on Drugs

Olusegun Obasanjo served as President of the Federal Republic of Nigeria from 1999 until 2007. Upon leaving office, he oversaw the first civilian handover of power in Nigeria from one democratically-elected leader to another. President Obasanjo's administration tackled corruption as a major priority, establishing dedicated bodies and strengthening existing ones.

On a regional level, President Obasanjo has played a pivotal role in the regeneration and repositioning of the African Union with the African Peer Review Mechanism (APRM) and the New Partnership for Africa's Development (NEPAD). He has consistently supported the deepening and widening of regional cooperation through the Economic Community of West African States (ECOWAS) and the Co-prosperity Alliance Zone.

He has at different times served as Chairman of the Group of 77, Chairman of the Commonwealth Heads of Government Meeting, Chairman of the African Heads of State and Government Implementation Committee on NEPAD, and today serves on the African Progress Panel to monitor and promote Africa's development. He was also involved in international mediation efforts in Namibia, Angola, South Africa, Mozambique and Burundi. In 2008, United Nations Secretary-General Ban Ki-moon appointed President Obasanjo as his Special Envoy on the Great Lakes.

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Helen Clark

Former Prime Minister of New Zealand and Administrator of the United Nations Development Programme (UNDP)

Helen Clark became the Administrator of the United Nations Development Program in April 2009 and the Chair of the United Nations Development Group, a committee consisting of the heads of all UN funds, programmes and departments working on development issues. She was the first women to assume these positions, which she held for a full two terms and eight years before standing down in April 2017.

Helen Clark's tenure coincided with a period of increased worldwide volatility, which included the aftermath of the financial crisis, uprisings in the Arab States' region, increasing extreme weather events and disasters, and a growth in the number of deadly conflicts and the associated forced displacement crises. Helen Clark refocused and reformed UNDP into a more transparent, efficient, and accountable organization which could better respond to the new environment while also ensuring that it kept its long term focus on human and sustainable development.

Helen Clark is a champion of inclusive and sustainable development. She has ensured that UNDP's work on poverty eradication is closely linked with its governance and environmental portfolios. She has advocated for the full inclusion and empowerment of women in development – and within UNDP itself where during her tenure the ratio of women to men reached fifty per cent. Helen Clark advocates for sexual reproductive health and rights, an end to violence against women and for LGBTI rights. She has long advocated for those living with HIV and AIDS, and for effective prevention and treatment. At UNDP Helen Clark became known as an early adopter of social media platforms, speaking directly to the public and being ranked as the UN's most influential leader on social media.

Prior to her appointment with UNDP, Helen Clark was the first woman elected as Prime Minister of New Zealand, serving three successive terms from 1999 to 2008. She engaged widely in policy development and advocacy across the international, economic, social, environmental, and cultural spheres. Under her leadership, New Zealand achieved significant economic growth, low levels of unemployment, and high levels of investment in education, health, and the well-being of families and older citizens. She and her government prioritized reconciliation and the settlement of historical grievances with indigenous people, and the development of an inclusive multicultural and multi-faith society. She advocated strongly for New Zealand's comprehensive programme on sustainability, including on addressing climate change.

Helen Clark held ministerial responsibility during her nine years as Prime Minister for the portfolios of arts, culture and heritage, human and signals intelligence, and ministerial services. She was a strong promoter of the role of arts, culture and heritage in expressing the unique identity of New Zealand.

First elected to Parliament in 1981, Clark was re-elected to her multicultural, inner city Auckland constituency for the tenth time in November 2008. Between 1987 and 1990, she was a Minister responsible for first, the portfolios of Conservation and Housing, and then Health and Labour. She was Deputy Prime Minister between 1989 and 1990, Deputy Leader of the Opposition and of the New Zealand Labour Party from 1990 to 1993, and then Leader of the Opposition and of the Labour Party until becoming Prime Minister after the 1999 General Election.

Helen Clark graduated from the University of Auckland with a BA in 1971, and an MA with First Class Honours in 1974.

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Nick Clegg

Former Deputy Prime Minister, UK

Nick Clegg MP is a Liberal Democrat politician who served as Deputy Prime Minister in Britain's first post war Coalition Government from 2010 to 2015 and as Leader of the Liberal Democrats from 2007 to 2015. He served as the Member of Parliament for Sheffield Hallam from 2005-2017, and was previously a Member of the European Parliament.

Nick Clegg led his party into Government for the first time in its modern history in a coalition with the Conservatives. As Deputy Prime Minister, Nick Clegg occupied the second highest office in the country at a time when the United Kingdom was recovering from a deep recession following the banking crisis of 2008. Despite the hugely controversial decisions needed to restore stability to the public finances, Nick Clegg successfully maintained his party's support for a full five-year term of office.

During that time, he was at the heart of decisions surrounding national security and civil liberties, the referenda on electoral reform and Scottish independence, and extensive reforms to the education, health and pensions systems. He was particularly associated with landmark changes to the funding of schools, early years education and the treatment of mental health within the NHS.

He remains an outspoken advocate of civil liberties and 'centre-ground' politics, of radical measures to boost social mobility, and of an internationalist approach to world affairs.

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Michael Kazatchkine

Professor of medicine, former Executive director of the Global Fund to fight AIDS, Tuberculosis and Malaria

Michel D. Kazatchkine was Executive Director of the Global Fund to Fight AIDS, Tuberculosis and Malaria from 2007 to 2012. The Global Fund, based in Geneva, Switzerland, is the world's leading multilateral financier of programs for the three diseases and one of the major financiers of health systems strengthening. In 2012, then UN Secretary-General Ban Ki-Moon appointed him as United Nations Special Envoy for HIV/AIDS in Eastern Europe and Central Asia.

Dr Kazatchkine has spent the past 25 years fighting AIDS as a leading physician, researcher, administrator, advocate, policy maker, and diplomat. He attended medical school at Necker-Enfants-Malades in Paris, studied immunology at the Pasteur Institute, and has completed postdoctoral fellowships at St Mary's hospital in London and Harvard Medical School. His involvement with HIV began in 1983, when, as a young clinical immunologist, he treated a French couple who had returned from Africa with unexplained fever and severe immune deficiency. By 1985, he had started a clinic in Paris specializing in AIDS – which now treats over 1,600 people – and later opened the first night clinic for people with HIV in Paris, enabling them to obtain confidential health care outside working hours.

Dr Kazatchkine was Professor of Immunology at Université René Descartes and Head of the Immunology Unit of the Georges Pompidou Hospital in Paris. He has authored or co-authored of over 500 articles in peer reviewed journals, focusing on auto-immunity, immuno-intervention and pathogenesis of HIV/AIDS.

In addition to his clinical teaching and research activities, Dr. Kazatchkine has played key roles in various organizations, serving as Director of the National Agency for Research on AIDS (ANRS) in France (1998-2005), Chair of the World Health Organization's Strategic and Technical Advisory Committee on HIV/AIDS (2004-2007), member of the WHO's Scientific and Technical Advisory Group on tuberculosis (2004-2007), and French Ambassador on HIV/AIDS and communicable diseases (2005-2007). Dr Kazatchkine's involvement with the Global Fund to Fight AIDS, Tuberculosis and Malaria began when the organization was established in 2001. He was the first Chair of the Global Fund's Technical Review Panel (2002-2005) and has served as a Board member and Vice-Chair of the Board (2005-2006).

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Asma Jahangir

Human rights activist, former UN Special Rapporteur on Arbitrary, Extrajudicial and Summary Executions, Pakistan

Asma Jahangir is an advocate of the Supreme Court of Pakistan and has been twice elected as Chairperson of Human Rights Commission of Pakistan (HRCP) which was set up in 1986. She is also one of the Directors of AGHS Legal Aid Cell, established in 1980, providing free legal assistance to the needy. Asma Jahangir was instrumental in the formation of Punjab Women Lawyers Association (PWLA) in 1980 and Women Action Forum (WAF) in 1985. In 1998 she was appointed United Nations Special Rapporteur on Extrajudicial, Summary or arbitrary execution of the Commission on Human Rights. From 2004 to 2010, she served as United Nations Special Rapporteur on Freedom of Religion or belief of the Council on Human Rights.

Dr. Jahangir was put under house arrest and later imprisoned for participating in the movement for the restoration of political and fundamental rights during the military regime in 1983 and 2007. She was one of the leading figures in the campaign waged by the women activists against the promulgation of the controversial Hadood Ordinances and draft law on evidence.

She represented several clients who were denied their fundamental rights. Notable amongst them are the cases she fought for brick kiln workers, who are mostly bonded labourers in Pakistan. She represented them and was subsequently successful in getting a legislation passed through the parliament in favour of bonded workers. She has defended cases of discrimination against religious minorities, women and children. She defended three Christians, one amongst them a fourteen-year-old boy, accused of blasphemy. In her effort to secure justice for the disadvantaged groups she has been frequently threatened by militant groups. In 1995, the militants of a religious outfit attempted to murder Asma Jahangir and her family.

She has authored two books: Divine Sanction? The Hadood Ordinance 1988 and Child Prisoners of Pakistan. There are five papers to her credit. Child Labour, Bonded Labour and Slavery; Women, Tradition and Religion; The independence of Judiciary and Lawyers; Women's Movement in Pakistan; Strategies for Human Rights and Electoral Process in Pakistan. Asma Jahangir was conferred honorary degrees of Doctor of Law by University of St. Gallen, Switzerland, Queen's University, Kingston Canada, and the Amherst College, USA.

She is a recipient of number of international and national awards. Amongst these is the Ramon Magsaysay award in 1995.

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