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Review

Thinking upstream: the roles of international health and drug policies in public health responses to chemsex

Oliver Stevens[A,C] *and Jamie I. Forrest*[B]

[A]45C Northdown St, London, N1 9BL, United Kingdom.
[B]School of Population and Public Health, University of British Columbia, Vancouver, Canada.
[C]Corresponding author. Email: bolistevens@gmail.com

Abstract. Chemsex is a growing public health concern in urban centres, and few interventions exist to mitigate the significant sexual, drug-related, and social harms potentially experienced by people who participate in chemsex. In much of the world, these immediate harms are further compounded by the criminalisation and stigmatisation of both homosexuality and drug use, preventing participants fully engaging with treatment services or provision of health care. Gay, bisexual and other men who have sex with men participating in chemsex fall between the traditional definitions of key populations and consequently are poorly provided for by existing drug and sexual health frameworks. Aetiologically complex issues such as chemsex require multifaceted interventions that may fall outside conventional frameworks. Existing interventions have been designed and implemented at the local level. The use of international policy to mitigate these structural barriers, however, has largely been ignored. International policy is broad in nature and its implementation is, in principle, binding for member states. We believe that despite its low international prevalence, international policy can be of use in improving the lives of people who participate in chemsex. Through stimulating a much-needed debate on the interplay between sex and drugs within global health and harm reduction frameworks, this paper aims to address the paucity of substantial discussion surrounding the applicability of international language to chemsex. We analyse international policy aimed at addressing HIV, illicit drugs, harm reduction, and development, and make recommendations for both national advocacy, and advocates working to alter the positions of member states internationally.

Additional keywords: Commission on Narcotic Drugs (CND), gay men, injecting drug use, Joint United Nations Program on HIV/AIDS (UNAIDS), men who have sex with men, sexual behaviour, stimulant, Sustainable Development Goals (SDGs), UNGASS.

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The meaning and context of chemsex

Sexualised drug use ('chemsex') and, in particular, its characterisation within a subculture of gay, bisexual and other men who have sex with men (gbMSM), is a growing public and community health concern. While chemsex practices differ widely across the globe, some common features and behaviours can be identified. The use of stimulants and oral γ-hydroxybutrate/γ-butyrolactone (GHB/GBL) consumption, often in group settings, can lead to diminished inhibitions, potentially exposing participants to a plethora of sexual, drug-related and social harms.[1–3] Such harms and their aetiology have been discussed in detail elsewhere.[4–7]

While chemsex behaviours are not exclusive to high-income settings,[8–10] knowledge surrounding sexualised drug use and interventions to address this public health concern have emerged almost exclusively from research on gbMSM within epidemiological studies on HIV prevention in North America and Western Europe. From these studies, it is clear that gbMSM who engage in chemsex are more likely to be HIV positive and have a higher incidence of other sexually transmissible infections.[11] Engaging in chemsex has also been shown to be significantly associated with reporting inconsistent condom use.[12]

Chemsex is a complex health phenomenon. Local public health responses, both individual and community-level, have been developed and must continue to evolve with emerging evidence and expand in their accessibility and reach. Far upstream of these interventions lies an international policy environment that substantially influences the level of risk for gbMSM engaging in chemsex and shapes public health efforts. International policymaking, when guided by the core principles of inclusion and non-discrimination, can be a powerful mechanism for public health advocates, but a global dialogue on the role of international policy in shaping and mitigating the harms associated with chemsex has been absent to date. Note that we recognise that chemsex is highly

unlikely ever to feature within international language;[1] rather, the aim of this review is to utilise existing language in a chemsex context.

In this narrative review, we seek to examine how this phenomenon is currently reflected in global policy arenas of HIV, harm reduction and sustainable development. We highlight existing international policies that can be leveraged by public health advocates to improve the health and wellbeing of chemsex participants and identify policy areas where chemsex can be more explicitly articulated. We argue that a global HIV response that differentiates programming for gbMSM from that of drug users fails adequately to address the nexus of risk behaviour associated with chemsex.

This review may be of interest to two groups aiming to improve the health of gbMSM: advocates seeking to make use of policy derived at an international level within their national response; and those looking to influence and alter the behaviours of member states within the international arena itself. We first discuss the positioning of a public health response to chemsex within the context of the HIV pandemic *versus* one grounded in the principles of harm reduction. Finally, we discuss how a discussion of chemsex within the framework of the Sustainable Development Goals can potentially bridge this population-focussed divide in international policy. In each section, we outline the potential ways in which existing policy can be used to leverage an effective harm reduction response to those engaging in chemsex.

Chemsex within the context of a global HIV response: opportunities and challenges

A renewed re-conceptualisation of HIV as a disease disproportionately associated with key populations has informed the development and implementation of global interventions aimed at addressing harms associated with behaviours common among gbMSM. These interventions importantly include prioritising anti-retroviral treatment (ART) access for key populations and expanding access to preventative interventions such as post-exposure prophylaxis (PEP) and pre-exposure prophylaxis (PrEP). While effective, it is vital that the global community ensures that member states do not use the expansion of these clinical interventions as an excuse to shirk their own responsibility to instigate political and legislative change necessary for the control of HIV transmission; in particular, the decriminalisation of drug use and homosexuality.[13]

To reach the ambitious goal of achieving an AIDS-free generation, the Joint United Nations Programme on HIV/AIDS (UNAIDS) has aggressively campaigned for member states to reach the '90–90–90' target:[14] by 2020, 90% of people living with HIV know their status, of whom 90% are on treatment, and of whom 90% have a suppressed viral load. Thanks to longstanding advocacy efforts, UNAIDS and the World Health Organization (WHO) continually stress the importance of key populations within the global fight against HIV/AIDS. This is evident both in WHO clinical guidelines for treatment and prevention,[15] and in UNAIDS 90–90–90 progress reports.[16] UNAIDS data are routinely disaggregated by key population (including people who inject drugs (PWID) and gbMSM), enabling accurate and specific analysis of progress.[16] Illumination of this intersection should be encouraged and, given the progressive stance adopted by UN agencies on several issues, may be a prime opportunity for international visibility. The benefits of this are two-fold: it will improve the health of gbMSM who engage in chemsex;[17] and presents a relatively simple advocacy opportunity – HIV/AIDS will never be defeated by leaving key populations behind.

Regrettably, however, available data have shown not only that PWID and gbMSM have consistently lagged behind other populations in reaching the 90–90–90 goals,[16] but that epidemiological data on other key populations, in particular transgender women, remains sparse.[18] Although WHO has developed specific guidelines to address the needs of key populations,[19] no UN agency has yet given visibility to the intersection between drug use and homosexuality, despite studies showing a higher proportion of gbMSM use drugs more frequently than heterosexual men.[20] As international donor funding decreases and domestic spending by low- and middle-income countries increases, we have seen a decrease in funds allocated to harm reduction (and wider key population programming).[21] This is 'largely due to poor political will that manifests as none or very limited state support. More politically palatable programs [those *not* targeting PWID or gbMSM] are prioritised in many countries despite lower cost-effectiveness ratios.'[22]

Furthermore, despite advances in HIV science and clinical practice guidelines, one of the key barriers to improving access to HIV services for gbMSM engaging in chemsex is a current global funding and policy structure that allocates resources according to a model of mutually exclusive key populations. By structuring global funding mechanisms by disease, rather than by population, opportunities for intervention among populations that are also at-risk of non-HIV health issues may be missed. Indeed, multiplicative ('syndemic'[23,24]) experiences of stigma, discrimination and minority stress continue to be a reality for gbMSM and create an environment that perpetuates the harms associated with chemsex.[4,5,17,25] While the HIV/AIDS movement offers a prime opportunity for attracting resources to chemsex, it is not the be-all and end-all of gbMSM public health. Rather, a disproportionate focus on HIV obscures other key chemsex harms including drug-related death,[26] mental health issues[27,28] and social exclusion.[28] It is therefore critical that advocates press for morbidity and mortality to become indicators in policy evaluation, as called for by the World Health Assembly[29] and highlighted in a recent WHO report outlining a framework for people-centred, not disease-centred health services.[30] Advocates should be mindful of the mandates and limits of UN agencies. When considering other

[1]Internationally agreed language, or international language, is defined as text passed by consensus-basis at the United Nations, including the UN General Assembly and the Commission on Narcotic Drugs. Note that text produced by UN agencies, such as WHO, UNAIDS and UNODC is not included in this definition.

morbidities, WHO, over UNAIDS, may be more appropriate when looking to address psychosocial issues in gbMSM populations.

So central are criminalisation and stigmatisation to harm in key populations,[29,31] that they remain one of, perhaps the most, central barrier to progress in chemsex and indeed wider global lesbian, gay, bisexual, and transgender (LGBT) health.[32] UNAIDS, UN Development Programme, UN System Task Force and the Human Rights Council have called for the decriminalisation of drug use,[33] with the Special Rapporteur on the Right to Health noting that 'the right to health includes more than access to health services; it is also the right to the underlying determinants of health, including equality and non-discrimination'.[34] More recently, a 2017 Joint United Nations statement on ending discrimination in healthcare settings calls for the repeal of punitive laws that criminalise, among others, same sex conduct and drug use.[35] The statement, signed by 12 UN agencies (noting the absence of the UN Office on Drugs and Crime), is a firm and promising sign of UN coherence on public health-focussed drug policy.

While there remains an absence of global health funding structures that prioritise a more holistic approach to expanding health services for gbMSM beyond HIV (although local centres provide examples of good practice, see 56 Dean St case study in reference 16), the existing structures have, however, fostered the emergence of a global harm reduction movement.

Chemsex within the context of global drug control and harm reduction

In both Europe and North America, opioid users form the second largest group engaging with drug services, second only to those seeking treatment for alcohol dependency.[36–38] Consequently, and unsurprisingly, interventions to address the burden of HIV among PWID, and indeed harm reduction in general, have primarily been targeted at those who use opioids and not stimulants. However, among urban gbMSM participating in chemsex, use of opioids is not commonplace.[28]

It should be appreciated that the dearth of stimulant harm reduction interventions is an issue not restricted only to gbMSM. Currently, recommendations guiding the implementation of harm reduction interventions for stimulant injectors do not extend far beyond needle and syringe programs (NSPs).[39–41] The UN Office on Drugs and Crime (UNODC) and WHO agree: 'the existing evidence base for stimulant harm reduction needs to be better collated and communicated'.[42] Heterosexual methamphetamine use is widespread across South-East Asia, Australia and North America,[43] where the lack of stimulant harm reduction initiatives is a growing cause for concern. Fledgling initiatives have been trialled, including dextroamphetamine and modafinil as amphetamine substitution therapies, albeit with limited efficacy.[44–46]

Previous qualitative work indicates that people engaging in chemsex in need of treatment and supportive services frequently avoid engaging with these services because they do not identify with the image of a drug service client or feel unwelcome and alienated, finding their circumstances poorly understood and their needs poorly met.[4,47] The global HIV/AIDS movement of the last 40 years, however, has transformed the sexual health services environment. As a result of years of community strengthening and capacity building, at least in high-income countries, existing spaces are often 'gay-friendly' and are familiar to gbMSM as settings where non-judgemental healthcare and HIV testing can be accessed. As chemsex is 'often a normal part of [participants'] sex lives, weekends and general lifestyle',[48] abstinence may result in the loss of friends, sexual partners, identity and, indeed, oft-overlooked factors in illicit drug dialogue:[49] pleasure and enjoyable experiences. If chemsex were re-framed as a sexual health issue, rather than one of drug dependence, and harm reduction interventions which facilitate safer chemsex and permit on-going drug use encouraged, this may result in better service engagement and outcomes than abstinence-based programs.[4,17,50]

Though stimulant harm reduction presents a challenging advocacy opportunity, the high international prevalence of stimulant use circumvents a central issue frequently encountered in other avenues aiming to draw attention to chemsex – the fact that, compared with other health phenomena, chemsex is one of very low prevalence. Consequently, it may be unreasonable to expect chemsex to feature prominently (if at all) within existing international language. After years of hard-fought advocacy, international language does now include the term 'key population'. However, there remains little consideration of the hypothetical individual who is a member of multiple key populations; for example, LGBT and a person who uses drugs. Accordingly, there exists a consistent failure to recognise overlapping, or indeed syndemic, vulnerabilities at both the international and national levels.

Furthermore, LGBT issues have been excluded from the policy-making agenda of many of the most influential bodies of the United Nations, including the General Assembly and the Commission on Narcotic Drugs (CND), the principal decision-making body of the UN drug control architecture. While drug control impacts most acutely on individuals' health and human rights, national discussions at CND have traditionally focussed on law enforcement and criminal justice, measuring its success in number of drug seizures or hectares of opium poppy destroyed, rather than indicators of drug-associated morbidity and mortality. Furthermore, given the number of conservative member states participating in the CND consensus-based processes, deviation from a criminal justice focus has proven arduous, with the inclusion of LGBT-specific language impossible. It is telling that the first CND resolution pertaining to overdose was passed only in 2012, and restricted only to matters of opioid use.[51]

In 2012, dissatisfied with the repressive focus of global drug control, Mexico, Guatemala and Colombia called for an urgent debate on the direction of international drug policy to 'move beyond prohibition'[52] – resulting in a UN General Assembly Special Session on the Drug Problem (UNGASS), which was convened in April 2016. The 2016 UNGASS was a landmark moment in drug policy. Despite not fulfilling the hopes of many within the policy reform movement, the UNGASS Outcome Document broadened the debate on drugs away from traditional discussions on pure prohibition to include new, progressive thematic areas – including health, human rights and development.[53] Under the banner of 'system-wide

coherence',[2] UN agencies took on a more central role than ever before, encouraging CND and UNODC to move away from 'repressive responses to drug use and non-violent low level drug offences [that] pose unnecessary risks to public health and create significant barriers to the full and effective realisation of the right to health, with a particularly devastating impact on minorities (...) and people who use drugs.'.[34] Notable progressive statements from UN agencies, including UNAIDS, WHO, UN Women and the Office of the High Commission on Human Rights,[33] served to 'expand and diversify the perspectives brought to bear upon the fundamentally cross-cutting issue of drugs'.[54] Accordingly, increased system-wide coherence represents a positive step that will likely elevate the position of health and human rights – and therefore offer a crucial opportunity to begin discussions on intersectional issues of race, sexuality, gender identity and drug use – within the context of international drug control.

Within international language on both drugs and HIV, 'harm reduction' remains politically sensitive. It concedes that drug use is here to stay, and that the stated aim of international drug control, a drug-free world, is an unobtainable fantasy. Instead, the Outcome Document[53] resorts to 'effective measures aimed at minimising the adverse public health and social consequences of drug abuse'. Regardless of lexicon, it remains the most progressive piece of agreed language on harm reduction and drug dependence treatment: it supports the use of NSPs and opioid substitution therapy; recognises drug dependency as a health issue; and encourages voluntary over mandatory treatment programs. Member states are also obliged to provide 'non-discriminatory access' to harm reduction and drug treatment. A focus of chemsex advocacy should be non-discriminatory access to health care including, where available, harm reduction services.

Within UN resolutions, mentions of human rights and harm reduction interventions continue to be caveated with phrases such as 'in accordance with national legislation' and 'as/when applicable', providing member states with leeway to continue to enforce repressive national law.[55] As the international community moves towards the review of the existing Political Declaration on Drugs in 2019, advocates and progressive member states must not only fight to retain the progressive language agreed upon in the 2016 Outcome Document, but also build upon it and shine light upon politically unsavoury issues such as chemsex.[56]

Consensus-based negotiations restrict not only CND, but also the UN General Assembly meetings on HIV, although the latter meetings are often considered as more accepting of the needs of key populations. Nevertheless, the 2011 and 2016 Political Declarations on HIV/AIDS,[57,58] comprising a total of 180 paragraphs, make only two references to gbMSM and eight to PWID. Given that gbMSM and PWID comprised 20% of new global HIV infections in 2015 (12% and 8% respectively) and 42% in regions outside Sub-Saharan Africa (22% and 20% respectively), this lack of visibility is concerning.[16] Perhaps more concerning is that the 2016 Declaration includes weaker, more convoluted language by comparison with that agreed in 2011; the 2016 Declaration makes no mention of the harm reduction-endorsing *WHO, UNODC and UNAIDS Technical Guide for Injecting Drug Users*,[59] nor does it set a target for reduction in new HIV infections in PWID, both of which featured in the 2011 Declaration. The omission of a new target in the 2016 Declaration may be a result of the comprehensive failure to meet the targets of its predecessor; rather than halving new HIV infections in PWID by 2015, an increase of 33% was recorded.[60] Chemsex advocacy pertaining to HIV may, therefore, be better focussed around UNAIDS 90–90–90, whose progressive language and disaggregated reporting provide more opportunities than the consensus-based language of the General Assembly.

Given that CND has only recently begun to include gender-specific language, thereby accepting that women have different needs to men, LGBT-specific language remains a distant prospect. Perhaps promisingly, the 2030 Sustainable Development Goals (SDGs), the successors to the Millennium Development Goals, offer more inclusive language that may help provide a policy bridge for the rights of both drug users and sexual minorities.

Considering chemsex through the lens of the Sustainable Development Goals

The SDGs, adopted by member states in 2015, detail 169 ambitious targets categorised under the umbrellas of 17 goals, which aim to 'end poverty, protect the planet and ensure prosperity for all' by 2030.[61] Just as CND is restricted by its consensus-basis decision-making, so too were the discussions and negotiations of the Development Agenda, which lead to the SDGs. Consequently, references to LGBT individuals were removed in early drafts, although inclusive language has ensured the SDGs potential applicability to all.[62] It is of note that CND endorsed the SDGs during the 2016 UNGASS,[53] thus UNODC's activities and those of member states attempting to fulfil matters agreed at the CND must, theoretically, be done in line with the SDGs.

Several entry points are offered by the SDGs, centred around health care and ending discrimination (Box 1). Goals 3.3 (though better approached by UNAIDS 90–90–90) and 3.5 are of direct relevance to tackling the harms associated with chemsex through a clinical lens. Arguably of higher priority are SDGs 10.3 and 16.12 as 'criminal laws (...) have the clear health-deterrent effect of driving people away from the health services they need, impeding responses to HIV, hepatitis C, overdose, and drug dependence'.[34] Regrettably, in SDG 3.5, no mention is made of 'evidence-based' or 'with regard for human rights'.[53,63,64]

[2]"The principle of 'system-wide coherence' was introduced to make the UN's work more effective and coherent by integrating and connecting the many areas within which the organisation is active. [The actions of UN agencies involved in drug control should be] adequately balanced and coordinated with other relevant areas of international cooperation, such as economic and social development, the promotion of public health, and the protection of fundamental human rights and freedoms."

Box 1. Chemsex advocacy targets within the Sustainable Development Goals

Goal 3. Ensure healthy lives and promote well-being for all at all ages
- 3.3 End the epidemics of HIV/AIDS, (. . .) combat hepatitis, (. . .) and other communicable diseases.
- 3.5 Strengthen the prevention and treatment of substance abuse, including narcotic drug abuse and harmful use of alcohol.
- 3.6 Ensure universal access to sexual and reproductive healthcare services.

Goal 10. Reduce inequality within and among countries
- 10.3 Ensure equal opportunity and reduce inequalities of outcome, including by eliminating discriminatory laws, policies and practices and promoting appropriate legislation, policies and action in this regard.

Goal 16. Promote just, peaceful and inclusive societies
- 16.3 Promote the rule of law at the national and international levels and ensure equal access to justice for all.
- 16.12 Promote and enforce non-discriminatory laws and policies for sustainable development.

Goal 17. Revitalise the global partnership for sustainable development
- 17.17 Encourage and promote effective public, public–private and civil society partnerships, building on the experience and resourcing strategies of partnerships.

Unlike the Millennium Development Goals, which focussed on developing countries with a central health component, the SDGs are globally applicable and broader in scope. Regrettably, their breadth of application has not been reflected in its indicators nor in a requirement for disaggregated data. To account for varying national capacity between member states, the supporting Declaration concedes that 'each Government [will set] its own national targets guided by the global level of ambition but taking into account national circumstances'.[65] Whereas the language of the SDGs is all-encompassing, indeed its mantra is 'leave no-one behind', the absence of LGBT-specific language will allow member states to achieve laudable progress towards a goal while ignoring or actively discriminating against this small key population, let alone a further sub-section: people who engage in chemsex.

Progress on a selection of goals is evaluated annually at the High-Level Political Forum on Sustainable Development (HLPF). In 2017, the HLPF invited member states to submit voluntary reviews on six SDGs, including Goal 3. Forty-four countries did so, many of which elected wholly to ignore several targets. Few discussed SDG 3.6, with Thailand actively drawing attention to its mandatory drug treatment program,[66] which has been lambasted for lack of efficacy and human rights abuses.[67–69] Those that did discuss SDG 3.3 did so without reference to gbMSM or PWID, with Nigeria noting 'the prevention of mother-to-child [HIV] transmission is accorded priority'.[70]

While it is disappointing, though not unsurprising, that many member states elect to omit gbMSM and PWUD from their national reporting, it is more concerning that a similar pattern is seen from the UN itself. Neither Goal 3.3 nor Goal 3.6 are discussed within the Sustainable Development Goals Report 2017,[71] though the UN Statistical Division notes that 'the selection of indicators does not intend to represent a selection of the targets based on their importance, as all Goals and targets are equally important'.[72] Member states should be encouraged not only to report on all targets within a goal, but also to disaggregate reporting data by key population, to evaluate better whether progress has been achieved in a non-discriminatory manner. This is not a novel concept – the fight for fully disaggregated data by gender is ongoing; indeed, disaggregation by sexual orientation was raised at the 2016 HLPF.[73,74]

SDG Goal 10 is to be reviewed at the HLPF in 2019, which will be a key test of the global integration of marginalised populations. It is important that the needs and challenges facing key populations, particularly those that intersect or overlap (such as those engaging in chemsex), do not fall between the cracks of reporting, global monitoring or policy development.

Conclusions

International language, including the 2011 and 2016 Political Declarations on HIV/AIDS and the UNGASS Outcome Document, is restricted by consensus-basis decision-making and makes little reference to gbMSM generally, let alone chemsex specifically. However, the UNGASS Outcome Document has elevated the position of public health and enshrined the right to non-discriminatory access to health care and treatment. Progressive member states must ensure that the global community does not revert to the more prohibitionist stance of previous years.

By contrast, publications from most UN agencies and other supranational bodies encourage substantially more progressive positions towards key populations, people-focussed health systems and, crucially, are making data disaggregation commonplace. A recent report[41] from the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) recommends such a multifaceted approach and highlights responses to chemsex as an area in need of development. The EMCDDA appears to be taking a proactive role, having previously noted chemsex's relevance in the context of new psychoactive substances,[75] and its elevation to that of an issue that requires international attention and collaboration should be welcomed. While the positions of such bodies are non-binding, they hold

considerable weight and advocates should press for them to be integrated into national policy.

Much of the harm associated with chemsex is grounded in the criminalisation and stigmatisation shouldered by gbMSM who use drugs. They prevent empowerment and inclusion, and on a more immediate level, engagement with health care. Overcoming the substantial political and social barriers will require coordinated efforts from civil society, healthcare providers and, internationally, progressive member states. We note that breadth of the SDGs permit a response in kind and offer the most inclusive language yet agreed upon in international policy, but it is important to remember that the SDGs and their nebulous indicators are only as good as the advocacy efforts based upon them.

Though chemsex has been the focus of this review, many of the positions adopted can similarly be applied to other individuals who straddle key populations and for whom existing frameworks do not cater. Though the provenance of the existing frameworks is understandable, we suggest that sexual health and drug treatment programming operates in isolation and should be more integrated, better to serve intersectional needs.

Conflicts of interest

The authors declare no conflicts of interest.

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