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Right of everyone to the enjoyment of the highest attainable standard of physical and mental health

Note by the Secretary-General

The Secretary-General has the honour to transmit to the members of the General Assembly the report submitted by Anand Grover, Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, in accordance with Human Rights Council resolution 6/29.

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Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health

Summary

The current international system of drug control has focused on creating a drug-free world, almost exclusively through use of law enforcement policies and criminal sanctions. Mounting evidence, however, suggests this approach has failed, primarily because it does not acknowledge the realities of drug use and dependence. While drugs may have a pernicious effect on individual lives and society, this excessively punitive regime has not achieved its stated public health goals, and has resulted in countless human rights violations.

People who use drugs may be deterred from accessing services owing to the threat of criminal punishment, or may be denied access to health care altogether. Criminalization and excessive law enforcement practices also undermine health-promotion initiatives, perpetuate stigma and increase health risks to which entire populations — not only those who use drugs — may be exposed. Certain countries incarcerate people who use drugs, impose compulsory treatment upon them, or both. The current international drug control regime also unnecessarily limits access to essential medications, which violates the enjoyment of the right to health.

The primary goal of the international drug control regime, as set forth in the preamble of the Single Convention on Narcotic Drugs (1961), is the "health and welfare of mankind", but the current approach to controlling drug use and possession works against that aim. Widespread implementation of interventions that reduce harms associated with drug use — harm-reduction initiatives — and of decriminalization of certain laws governing drug control would improve the health and welfare of people who use drugs and the general population demonstrably. Moreover, the United Nations entities and Member States should adopt a right to health approach to drug control, encourage system-wide coherence and communication, incorporate the use of indicators and guidelines, and consider developing a new legal framework concerning certain illicit drugs, in order to ensure that the rights of people who use drugs are respected, protected and fulfilled.

Contents

I. Introduction

1. In its resolution 6/29, the Human Rights Council requested the Special Rapporteur to submit an interim report to the General Assembly. The Council, in its resolution 12/24, also encouraged the Special Rapporteur to integrate, within his existing mandate, the human rights dimensions of access to medicines. The present report is submitted in accordance with those requests.

2. Since his last report to the General Assembly (A/64/272), the Special Rapporteur has undertaken a number of activities to develop the mandate further and raise awareness of the right to health globally. As well as undertaking country missions to Australia in November 2009 and Guatemala in May 2010, the Special Rapporteur participated in a number of consultations and conferences on the right to health, including a parliamentarians' consultation on maternal health in the Asia-Pacific region in Bali; a civil society consultation on migrant workers and health organized by Coordination of Action Research on AIDS & Mobility, CARAM-Asia, in Kuala Lumpur; the Global Partners in Action NGO Forum for the review of the International Conference on Population and Development (ICPD@15) in Berlin; and the XVIII International AIDS Conference in Vienna in July 2010.

3. The Special Rapporteur also gave keynote presentations at New York University and Columbia University; the Stakeholders' meeting of the Human Rights Development Initiative in Johannesburg; the International Conference on Realizing the Rights to Health and Development for All in Viet Nam; the Cervical Cancer Summit Meeting at the European Parliament in Brussels; the Judiciary and the Right to Health Conference held at Princeton University; and the HealthRight International Annual Health and Human Rights Awards Dinner in New York. The Special Rapporteur also gave lectures during a course on the Justiciability of Economic, Social and Cultural Rights at the Institute for Human Rights, Åbo Akademi University, Turku/Åbo, Finland.

4. The Special Rapporteur held a civil society consultation in Guatemala in March 2009, bringing together civil society organizations from across Central America. This consultation provided an excellent opportunity to gain information that proved essential to completing the country mission in Guatemala in May 2009. The Special Rapporteur also attended a consultation in Afghanistan with a particular focus on paediatric and maternal health at the invitation of Save the Children.

5. The present report of the Special Rapporteur considers demand-side measures related to drug control — those primarily concerned with use and possession of drugs — and their various impacts on the enjoyment of the right to health. It discusses the need for an increased focus on human rights within drug control, instead of pursuing overly punitive approaches that result in more health-related harms than those they seek to prevent.

6. The Special Rapporteur recommends that human rights be integrated into the international response to drug control, through use of guidelines and indicators relating to drug use and possession, and that the creation of an alternative drug regulatory framework should be considered. Additionally, Member States should ensure that harm-reduction measures and drug-dependence treatment services are available to people who use drugs, especially focusing on incarcerated populations. They also should reform domestic laws to decriminalize or de-penalize possession and use of drugs, and increase access to controlled essential medicines.

II. The right to health and international drug control

7. The enjoyment of the right to health of all people who use drugs — and are dependent on drugs — is applicable irrespective of the fact of their drug use. It is important that drug use and drug dependence are not conflated: drug dependence is considered a chronic, relapsing disorder[1] involving altered brain function[2] that may require medical treatment, ideally utilizing a "biopsychosocial" approach.[3] By contrast, drug use is not a medical condition and does not necessarily imply dependence. Indeed the majority of people who use drugs do not become dependent and do not require any treatment.

8. The right to health seeks, inter alia, to ensure access to quality health facilities, goods and services without discrimination, including on the grounds of physical or mental disability, or health status.[4] Article 2, paragraph 2, and article 3 of the International Covenant on Economic, Social and Cultural Rights also prohibit discrimination in achieving realization of all rights within the Covenant. As such, an individual's use of drugs cannot constitute grounds for curtailing her/his rights,[5] irrespective of whether she or he has a recognized dependence syndrome or whether the applicable drug control regime allows for imprisonment or other sanctions. People who use drugs and people who are dependent on drugs possess the same freedoms and entitlements guaranteed by international legal instruments, and both groups experience violations of their rights under the current international drug control regime.

9. Three treaties form the core legal framework of the United Nations international drug control regime: (a) the Single Convention on Narcotic Drugs (1961) as amended by the 1972 Protocol, which consolidated previous international agreements and brought plants such as marijuana, coca and the opium poppy under international control; (b) the Convention on Psychotropic Substances (1971), which did the same for synthetic substances and precursor chemicals used in manufacturing drugs; and (c) the United Nations Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances (1988), which increased the scope and intensity of international policing of the drug trade and highlighted the connection between the drug trade and organized crime.[6] These treaties currently bring hundreds of illicit substances under international control,[7] criminalizing virtually every aspect of the unauthorized production and distribution of those substances, although production, distribution and possession for medical and/or scientific

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[1] See *Official Records of the Economic and Social Council, 2010, Supplement No. 8* (E/2010/28), p. 47.

[2] World Health Organization, *Neuroscience of Psychoactive Substance Use and Dependence* (Geneva, 2004), pp. 13 and 22.

[3] United Nations Office on Drugs and Crime and WHO, *Principles of Drug Dependence Treatment: Discussion Paper* (Geneva, 2008), p. 1.

[4] Committee on Economic, Social and Cultural Rights, General Comment No. 14 (2000) (E/C.12/2000/4), paras. 18 and 19.

[5] Nevanathem Pillay, United Nations High Commissioner for Human Rights, "High Commissioner calls for focus on human rights and harm reduction in international drug policy" (10 March 2009). Available from www2.ohchr.org.

[6] See E/CONF.82/15 and Corr.1 and 2, article 3, para. 5.

[7] International Narcotics Control Board, *List of Narcotic Drugs Under International Control* (48th ed., Vienna, 2008).

purposes is permitted.[8] The treaties have been ratified by over 181 States and have guided the development of drug policies throughout the world.

10. A number of United Nations bodies enforce the three drug control treaties and are required to promote and protect human rights, as identified in Articles 1 and 55 of the Charter of the United Nations. When the goals and approaches of the international drug control regime and international human rights regime conflict, it is clear that human rights obligations should prevail. The General Assembly has consistently adopted resolutions declaring that international drug control must be carried out in conformity with the Charter, and "with full respect for human rights" (see resolutions 62/176 and 63/197).

11. The primary goal of the international drug control regime is the protection of the health and welfare of mankind, through decreasing the illegal use and supply of controlled substances while ensuring access to controlled substances for medical and scientific purposes.[9] Despite this, explicit consideration of human rights is absent in the treaties and has lacked priority among the implementing bodies.

12. The International Narcotics Control Board oversees implementation of all three drug conventions. It monitors illicit drug production and trade, as well as access to controlled substances for scientific and medicinal purposes, and has the authority to investigate Governments that do not comply with treaty requirements. The Commission on Narcotic Drugs classifies narcotic and psychotropic drugs under different levels of restriction and serves as the governing body for the United Nations International Drug Control Programme within the United Nations Office on Drugs and Crime (UNODC). The Office is mandated "to contribute to the achievement of security and justice for all by making the world safer from drugs, crime and terrorism".[10]

13. Although the drug control bodies rarely have engaged in constructive human rights-related discussions in the past,[11] recently there has been a welcome shift towards incorporating human rights-based approaches into their work. UNODC has examined ways in which drug control can be synchronized better with the protection of human rights,[12] and the President of the International Narcotics Control Board recently met informally for the first time with civil society representatives.[13] The Commission on Narcotic Drugs also adopted a resolution concerning the promotion of human rights in implementing the international drug control treaties, and has considered the issues of HIV/AIDS and access to medicines in other resolutions.[14] Nevertheless, it is clear that significantly more must be done to make human rights central to drug control.

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[8] See the Single Convention on Narcotic Drugs, 1961, 30 March 1961, United Nations, *Treaty Series*, vol. 520, article 36.

[9] Single Convention on Narcotic Drugs, 1961, preamble and article 2.

[10] A/65/6 (Prog. 13), para. 13.4.

[11] The International Narcotics Control Board had explicitly stated that it would not discuss human rights or engage with civil society: Mr. Koli Kouame, Secretary of the International Narcotics Control Board, Press Conference, New York, 7 March 2007. Webcast available at http://157.150.195.10/webcast/pc2007.htm (Date of last access: 14 February 2008).

[12] See E/CN.7/2010/CRP.6.

[13] International Drug Policy Consortium, *The 2010 Commission on Narcotic Drugs — Report of proceedings* (London, 2010), p. 8.

[14] See resolution 49/4 (E/CN.7/2006/10), resolution 51/12 (E/CN.7/2008/15) and resolution 53/9 (E/CN.7/2010/18).

14. Unfortunately, the current approach to global drug control maintains that drugs are an undisputable "evil", which the international community has a "duty to combat".[15] The concept of a war on drugs is used to justify extreme policies and practices.[16] The links drawn between drug production and the funding of armed groups, for example between opium growers and the Taliban in Afghanistan, have further justified a zero-tolerance approach, even though such policies are increasingly shown to be ineffective in reducing the supply of and demand for drugs.[17] Therefore, this approach not only fails to achieve its primary stated aim — preventing health-related harms of drug use — but also fails to achieve genuine drug control.

15. The war-on-drugs approach also fails to acknowledge the realities of drug use and dependence and, for that reason, has been unsuccessful in achieving its stated aims. First, people invariably continue using drugs irrespective of criminal laws, even though deterrence of drug use is considered the primary justification for imposition of penal sanctions.[18] Second, drug dependence, as distinct from drug use, is a medical condition requiring appropriate, evidence-based treatment — not criminal sanctions.[19] Finally, punitive drug control regimes increase the harms associated with drug use by directing resources towards inappropriate methods and misguided solutions, while neglecting evidence-based approaches.

16. Drug use may have harmful health consequences, but the Special Rapporteur is concerned that the current drug control approach creates more harm than the harms it seeks to prevent. Criminalization of drug use, designed to deter drug use, possession and trafficking,[20] has failed.[18] Instead, it has perpetuated risky forms of drug use, while disproportionately punishing people who use drugs. Its ramifications for the health of the wider community, particularly in relation to HIV/AIDS, are no less severe: the 2010 Vienna Declaration notes that the criminalization of illicit drug users is fuelling the HIV epidemic.[21] Millennium Development Goal 6 requires States to commit to halting and beginning to reverse the spread of HIV/AIDS by 2015 (see General Assembly resolution 55/2), but continuing criminalization directly contradicts several multilateral health policies.[22]

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[15] Single Convention on Narcotic Drugs, 1961, preamble.

[16] See P. Gallahue, "Targeted Killing of Drug Lords: Traffickers as Members of Armed Opposition Groups and/or Direct Participants in Hostilities", *International Yearbook on Human Rights and Drug Policy*, vol. 1 (2010).

[17] Latin American Commission on Drugs and Democracy, *Drugs and Democracy: Toward a Paradigm Shift* (2009), p. 7.

[18] R. Bluthenthal and others, "Collateral damage in the war on drugs: HIV risk behaviours among injection drug users", *International Journal of Drug Policy*, vol. 10, No. 1 (1999), p. 26.

[19] UNODC and WHO, *Principles of Drug Dependence Treatment: Discussion Paper* (Geneva, 2008), p. 1.

[20] S. Friedman and others, "Relationships of deterrence and law enforcement to drug-related harms among drug injectors in United States metropolitan areas", *AIDS*, vol. 20, No. 1 (2006), p. 93.

[21] *Vienna Declaration*, XVIII International AIDS Conference (AIDS 2010), p. 1.

[22] Michel Sidibé, Executive Director of the Joint United Nations Programme on HIV/AIDS (UNAIDS), "Parliament: The Heart of Governance", statement to the 122nd Inter-Parliamentary Union Assembly, Bangkok, 28 March 2010. Available from http://unaids.org.

III. Impact of drug control upon realization of the right to health

17. Health is a human right that is indispensable for the exercise of other human rights. Countries that are overly punitive in sentencing also violate other rights of people who use drugs. Thirty-two jurisdictions currently retain the death penalty for drug offences, some mandatorily.[23] Article 6 of the International Covenant on Civil and Political Rights allows for imposition of the death sentence only for "the most serious crimes" (General Assembly resolution 2200 A (XXI)). The Human Rights Committee and the Special Rapporteur on extrajudicial, summary or arbitrary executions have confirmed that drug offences do not meet those criteria, and thus executions for drug offences are in violation of international human rights law.[24]

18. Criminalization of drug use and possession are implicated in violation of several human rights, including the right to health. Other infringements of the right to health are less direct, but occur as by-products of the skewed focus of the international drug control regime: for instance, insufficient access to essential medications. The Special Rapporteur considers that each of these violations is traceable ultimately to a disproportionate focus on criminalization and law enforcement practices at the expense of the enjoyment of the right to health and reduction of harms associated with drugs.

A. Deterrence from accessing services and treatment

19. In countries where the "war on drugs" is zealously pursued or drug laws are enforced stringently, those who are dependent on drugs may be, and often are, discouraged from accessing health services. It is reported that in some countries this approach has reinforced the status of people who use drugs as social outcasts, driving drug use underground, compromising the HIV/AIDS response,[25] as well as discouraging people who use drugs from accessing treatment. And where HIV infections occur through unsafe injecting practices, seroprevalence among injecting drug users can be as high as 50 per cent.[25]

20. Those who use drugs may avoid seeking medical attention for fear that information regarding their drug use will be shared with authorities, which could result in arrest, imprisonment[26] or treatment against their will.[27] Use of drug registries — where people who use drugs are identified and listed, and their civil rights curtailed — also may deter individuals from seeking treatment, as violations of patient confidentiality are documented frequently in such jurisdictions.[28]

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[23] Human Rights Committee, General Comment No. 6/16 of 27 July 1982 (A/37/40, annex V). See International Harm Reduction Association, *The Death Penalty for Drug Offences: Global Overview 2010* (London, 2010), p. 11.

[24] See A/HRC/4/20, para. 53.

[25] United Nations Development Programme, *Thailand's Response to HIV/AIDS: Progress and Challenges* (Bangkok, 2004), p. 55.

[26] R. Jürgens and others, "People who use drugs, HIV, and human rights", *The Lancet* (2010), available from doi:10.1016/S0140-6736(10)60830-6, pp. 3 and 4.

[27] A/64/272, p. 23.

[28] Open Society Institute, *The Effect of Drug User Registration Laws on People's Rights and Health: Key Findings from Russia, Georgia, and Ukraine* (New York, 2009), p. 16.

21. Some States criminalize the carrying of needles, syringes and other drug paraphernalia, contrary to the International Guidelines on HIV/AIDS and Human Rights.[29] Fear of arrest and criminal sanctions might deter individuals from accessing needle and syringe programmes and carrying sterile equipment, which increases the likelihood of unsterile equipment use and disease transmission. Legislation penalizing people carrying such equipment — including outreach workers — has been recognized as a barrier to HIV control.[30]

B. Discrimination and stigma

22. People who use drugs are often subjected to discrimination in medical settings. Access to antiretroviral (ARV) therapy can be low for people who use drugs: in Eastern Europe, although 70 per cent of reported cases of HIV occurred among people who injected drugs, this group comprised 39 per cent of the total population of people living with HIV receiving ARV therapy.[31] This may be attributed to structural inequalities that impede access of these groups to the therapy; for instance, lack of targeted interventions. Cases of health-care providers, however, denying ARV treatment to people who use drugs also have been noted,[32] in direct contravention of a right-to-health approach.

23. Individuals may also be denied access to other medical treatments on the grounds of their prior or current drug use, where evidence does not exist to justify the denial of such treatment. For example, in the United Kingdom of Great Britain and Northern Ireland it is reported that past or current users of drugs have been denied treatment for the hepatitis C virus, contrary to official guidance, on the basis that they would not adhere to treatment.[33] Treatment adherence among people who use drugs is not necessarily lower, and should be assessed on an individual basis.

24. The stigma created or reinforced through punitive enforcement or treatment regimes also may increase health risks. Targeted abuse and violence towards people who inject drugs by authorities may increase users' risk of physical and mental illness.[34] Policing practices ranging from surveillance to use of excessive force have been noted to target vulnerable and marginalized populations, and these people ultimately internalize this social suffering and become complicit in their own subordination.[35]

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[29] United Nations publication, Sales No. E.06.XIV.4, p. 30.

[30] UNODC, UNAIDS and WHO, "Policy brief: provision of sterile injecting equipment to reduce HIV transmission", *Evidence for action on HIV/AIDS and injecting drug use* (Geneva, 2004), p. 2.

[31] WHO, UNAIDS and UNICEF, *Towards Universal Access: Scaling up priority HIV/AIDS interventions in the health sector* (Geneva, 2008), p. 24.

[32] D. Barrett and others, "Recalibrating the Regime", *The Beckley Foundation Drug Policy Programme*, Report Thirteen (2008), pp. 37 and 38.

[33] Ibid., p. 40.

[34] H. Cooper and others, "Characterizing Perceived Police Violence: Implications for Public Health", *American Journal of Public Health*, vol. 94, No. 7 (2004), p. 1116.

[35] T. Rhodes, "Risk environments and drug harms: A social science for harm reduction approach", *International Journal of Drug Policy*, vol. 20, No. 3 (2009), p. 196.

C. Increased risks while using drugs

25. Criminalization of drug use also increases the risks to which people who use drugs are exposed through alteration of drug-ingestion behaviours, as well as drug composition. Although contamination with benign substances is more common than harmful ones,[36] the potential for harm resulting from a complete lack of regulation still exists. Recently, 33 cases of anthrax were confirmed among drug users in Scotland, attributable to contaminated heroin.[37]

26. Criminalization of drug use and possession also may lead to an increased risk of illness among people who use drugs. Higher rates of legal repression have been associated with higher HIV prevalence among people who use injecting drugs, without a decrease in prevalence of injecting drug use.[38] This is a likely result of individuals' adopting riskier injection practices such as sharing of syringes and injection supplies, hurried injecting, or use of drugs in unsafe places (such as needle-shooting galleries) out of fear of arrest or punishment.[39] Hurried preparation of drugs to avoid detection by law enforcement agents also predisposes people who inject drugs to an increased risk of overdose, vascular accident and infections, such as abscesses. These risks may be exacerbated by an individual's reluctance, out of fear, to utilize assistance in preparing and injecting drugs.[40]

27. Police crackdowns and other interventions associated with criminalization of drug use and possession also result in displacement of drug users from areas serviced by harm-reduction programmes, decreasing their ability to participate in needle and syringe programmes, opioid substitution therapy (OST) and access to outreach workers.[41] Access to emergency assistance in the instance of an overdose also is impeded, and the incidence of overdose may be increased by disrupting access to regular injecting networks and drug suppliers. Those most affected by displacement often are the most marginalized; for instance, the homeless, who cannot necessarily move indoors to use drugs.[41]

D. Disproportionate impact on vulnerable and marginalized communities

28. Punitive drug policies also disproportionately impact on communities that are already vulnerable. For instance, it has been reported that in the United States of America, African-Americans are arrested at consistently higher rates than white Americans, although the rates of offences committed are comparable between these groups.[42] Additionally, over 80 per cent of arrests are for possession of drugs, rather

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[36] C. Cole and others, "CUT: A Guide to Adulterants, Bulking Agents and Other Contaminants Found in Illicit Drugs", *Centre for Public Health, Liverpool John Moores University* (Liverpool, 2010), pp. 10 and 11.

[37] Health Protection Scotland, "Anthrax Confirmed in NHS Lothian Patient" (Glasgow, 12 April 2010). Available from www.documents.hps.scot.nhs.uk/.

[38] S. Friedman and others, op. cit., p. 97.

[39] Ibid.; see also Bluthenthal and others, op. cit., p. 31.

[40] Canadian HIV/AIDS Legal Network, *Do Not Cross: Policing and HIV Risk Faced by People Who Use Drugs* (Toronto, 2007), p. 6.

[41] Ibid., pp. 7 and 8.

[42] Human Rights Watch, *Decades of Disparity: Drug Arrests and Race in the United States* (New York, 2009), pp. 1 and 5.

than sales.[43] Accumulation of such minor offences can lead to incarceration and further marginalization of these already vulnerable individuals, increasing their health-related risks.

29. Currently over 9 million people are held in penal institutions worldwide.[44] In many prisons, rates of HIV infection are noted to be several times higher than in the mainstream community. This is attributed to injecting drug use prior to imprisonment, as well as risk factors within these populations, such as poverty and marginalization.[45] The prevalence of hepatitis infections within prisons is also high, with hepatitis C infection rates exceeding those of HIV.[46] Once in prison, high rates of injecting drug use, combined with a lack of access to OST and sterile injecting equipment, create enormous risk for inmates.[47] That risk is then passed on to members of the public upon prisoners' release.[46] Failure to implement effective harm-reduction programmes and drug-dependence treatment in those settings violates the enjoyment of the right to health.

IV. Compulsory treatment for drug dependence and infringements on the right to health

30. Some of the most egregious violations of the right to health have occurred in the context of "treatment" for drug dependence. Criminalization of drug use fuels the perception that people who use drugs are unproductive criminals or moral degenerates, which in turn allows disciplinary treatment approaches to proliferate. In place of evidence-based medical management, Governments and enforcement authorities coerce or force drug-dependent individuals into centres where they are subject to ill-treatment and forced labour. This approach discriminates against people who use drugs, denying them their right to access medically appropriate health-care services and treatment.

31. The present report concerns compulsory treatment programmes that primarily utilize disciplinary interventions, disregarding medical evidence. In such settings, medical professionals who are trained to manage drug dependence disorders as medical illnesses are often inaccessible.[48] Forced labour, solitary confinement and experimental treatments administered without consent violate international human rights law and are illegitimate substitutes for evidence-based measures such as substitution therapy, psychological interventions and other forms of treatment given with full, informed consent.

32. The enjoyment of the right to health includes, inter alia, access to health facilities, goods and services that are scientifically and medically appropriate and of

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[43] Ibid., p. 12.

[44] R. Walmsley, "World Prison Population List", *International Centre for Prison Studies* (7th ed., London, 2007), p. 1.

[45] International Harm Reduction Association, *State of Global Harm Reduction* (London, 2010), p. 105.

[46] Ibid., p. 106.

[47] A/HRC/10/44, paras. 55-67.

[48] See WHO, *Assessment of compulsory treatment of people who use drugs in Cambodia, China, Malaysia, and Viet Nam: An application of selected human rights principles* (Geneva, 2009). Available from www.wpro.who.int/NR/rdonlyres/4AF54559-9A3F-4168-A61F-3617412017AB/0/FINALforWeb_Mar17_Compulsory_Treatment.pdf (Accessed 10 June 2010).

good quality[49] and the "right to be free from interference, such as the right to be free from torture, non-consensual medical treatment and experimentation".[49] Moreover, article 7 of the International Covenant on Civil and Political Rights declares that "no one shall be subjected without his free consent to medical or scientific experimentation". States are obliged to respect, protect and fulfil the enjoyment of the right to health, including by refraining from using coercive medical treatments, except in the narrowest possible circumstances for the treatment of mental illness or the prevention and control of communicable diseases.[50] The requirements of informed consent must be observed in administering any treatment for drug dependence — including the right to refuse treatment.[51]

33. Compulsory treatment primarily infringes the right to health in two ways. First, this "treatment" generally disregards evidence-based medical practices, and thus fails to meet the quality element of the right to health, as elaborated by the Committee on Economic, Social and Cultural Rights.[52] Second, treatment is often conducted en masse and disregards the need for informed consent to be given on an individual basis.

34. Proper medical management of drug dependence requires that treatment be evidence-based. The catalogue of "treatment" in many compulsory treatment centres includes forced labour, detention, military-type drills, physical exercises and experimental treatment, among other interventions, of which the effectiveness is not backed by scientific evidence. Nearly 90 to 100 per cent of people who use drugs returned to drug use after being subjected to forced treatment in such centres.[53]

35. Reports indicate that some patients are subject to perverse therapies such as "flogging therapy".[54] Similarly, it has been reported that patients are forced to labour for nearly 17 hours a day, all week, under threat of beatings and other physical punishments.[55]

36. Such disciplinary treatments more often than not substitute for evidence-based methods. As a result, many people dependent on heroin and other opioids suffer through unmedicated withdrawal, instead of receiving pharmacologically supported withdrawal or OST. Classifying methadone and buprenorphine as illegal creates an extra barrier to accessing such drug-dependence treatments.[56] Imposition of compulsory treatment, at the expense of OST and other harm-reduction interventions, also increases the risk of disease transmission, particularly HIV/AIDS.[57]

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[49] General Comment No. 14 (2000) (E/C.12/2000/4), para. 12 (d).

[50] Ibid., para. 34.

[51] See A/64/272, paras. 28 and 88-91.

[52] General Comment No. 14 (2000) (E/C.12/2000/4), note 55.

[53] N. Crofts, "Treatment in Southeast Asia: The need for effective approaches", in *Open Society Institute Briefing on Drug Treatment, HIV, and the Challenge of Reform* (2006).

[54] V. Mendelevich, "Narcology: Drug treatment in Russia", in *Open Society Institute Briefing on Drug Treatment, HIV, and the Challenge of Reform* (2006).

[55] J. E. Cohen and J. J. Amon, "Health and Human Rights Concerns of Drug Users in Detention in Guangxi Province, China", Public Library of Science (*PLOS Med*, 5912): e234 2008.

[56] Open Society Institute, *At What Cost?: HIV and Human Rights Consequences of the Global "War on Drugs"* (New York, 2009), p. 87.

[57] See Open Society Institute, "Detention as Treatment" (May 2010); R. Pearshouse, "Compulsory Drug Treatment in Thailand: Observations on the Narcotic Addict Rehabilitation Act B.E. 2545 2002" (2009).

37. People also may be forced to undergo treatment that is unnecessary medically in some countries, where there is a reported lack of differentiation between occasional drug users and people who are dependent on drugs.[58] Many such individuals also may be subjected to experimental treatment. Any failure to provide the information necessary to enable the patient to give fully informed consent violates his/her enjoyment of the right to health.

38. As examined in a previous report of the Special Rapporteur,[59] informed consent to treatment is a cornerstone of the right to health, the requirements of which would be satisfied on extremely rare occasions in forced administration of punitive treatment. Decisions regarding capacity and competence, and the need to obtain informed consent, must be made on a case-by-case basis. Treatment en masse prima facie fails to meet this requirement. In some countries, it is reported that people who use drugs have been arrested en masse and forced into compulsory treatment centres.[60] This approach leads to forced treatment of individuals based on inadequate, cursory medical examinations — if they are undertaken at all.

39. People who use or are dependent on drugs do not automatically lack the capacity to consent to treatment. A presumption of incapacity based on drug use or dependence creates significant potential for abuse. In many cases, a determination of individual incapacity merely is a pretext for the compulsory "treatment" of people who use drugs. Rather than denying people who use drugs the right to participate in consensual treatment, appropriate support mechanisms should be provided to overcome any barriers to obtaining informed consent.

V. Access to controlled medicines

40. Millions of people worldwide require essential medicines for pain, drug dependency and other health conditions, but availability is often limited by restrictive drug regulations, failure to implement a properly functioning supply and distribution system, and inadequate health-care system capacity. An alarming availability gap exists between the developed and developing world in relation to the supply of essential medicines. Although the developing world has nearly half of the world's cancer patients and nearly all new HIV infections, it consumes only 6 per cent of the licit morphine supply.[61] About 89 per cent of all legally controlled medicines, including morphine is consumed by North America and Europe.[62] The Economic and Social Council, in its resolution 2005/25, recognized the need to remove barriers to accessing opioid analgesics,[63] and the International Narcotics

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[58] WHO, *Assessment of compulsory treatment of people who use drugs in Cambodia, China, Malaysia, and Viet Nam: An application of selected human rights principles* (Geneva, 2009). Available from www.wpro.who.int/.

[59] See A/64/272.

[60] See D. Barrett and others, "Recalibrating the Regime", *The Beckley Foundation Drug Policy Programme*, Report Thirteen (2008).

[61] *Report of the International Narcotics Control Board for 2007* (United Nations publication, Sales No. E.08.XI.1), p. 19. Available from www.incb.org/pdf/annual-report/2007/en/annual-report-2007.pdf.

[62] WHO, *Access to Controlled Medications Programme, Biennial Report 2006-2007* (WHO/PSM/QSM/2008), p. 1.

[63] E/2005/INF/2/Add.1, p. 70.

Control Board consistently has concluded that availability of essential controlled medicines is far too limited in many countries.[64]

41. These medications are often restricted excessively for fear they will be diverted from legitimate medical uses to illicit purposes.[64] Although preventing drug diversion is important, this risk must be balanced against the needs of the patient to be treated. The Single Convention on Narcotic Drugs recognizes the medical use of narcotic drugs that are indispensable for "the relief of pain and suffering".[65] UNODC and the International Narcotics Control Board possess oversight functions over States to ensure that drug control treaty obligations are implemented. As many barriers to adequate access to controlled essential medicines are regulatory, they can be changed quickly and inexpensively. However, many countries have failed to adapt their drug control systems to ensure adequate medication supply; those systems were often enacted before contemporary treatment methods for chronic pain and drug dependence were known or devised.[66] That constitutes an ongoing infringement of the right to health, as the Committee on Economic, Social and Cultural Rights has elaborated that access to essential medicines is a minimum core obligation of the right,[67] and States must comply immediately with this non-derogable obligation regardless of resource constraints.[68]

42. Restricted access to opioids has an obvious impact on the availability of OST (see discussion in section VI below). However, there are three other primary areas in which access to controlled medicines is essential: (a) management of moderate to severe pain, including as part of palliative care for people with life-limiting illnesses; (b) certain emergency obstetric situations; and (c) management of epilepsy.

43. Palliative care is an approach that seeks to improve the quality of life of patients diagnosed with life-threatening illnesses through prevention and relief of suffering.[69] Moderate to severe pain is a common by-product of these illnesses, including advanced malignancies, which require opioid analgesics for management.[70] WHO lists these and other analgesics, as essential medicines. Between 60 to 90 per cent of patients with advanced cancer suffer from moderate to severe pain requiring such analgesia, and around 85 per cent of people living with HIV may have untreated pain. Where patients with HIV are also dependent on drugs, they may be denied access to both OST and palliative care. The consequences of chronic, untreated pain are not only physical: people experiencing chronic pain are four times more likely to suffer from depression or anxiety.[71] Patients suffering

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[64] See *Report of the International Narcotics Control Board for 2008* (United Nations publication, Sales No. E.09.XI.1).

[65] Single Convention on Narcotic Drugs, 1961, preamble.

[66] WHO, *Achieving Balance in National Opioids Control Policy: Guidelines for Assessment* (Geneva, 2000), p. 6.

[67] General Comment No. 14 (2000), E/C.12/2000/4, para. 43.

[68] Ibid. para 47.

[69] WHO, *WHO Definition of Palliative Care* (Geneva, 2010). Available from www.who.int/cancer/palliative/definition/en/.

[70] WHO, *Pain Relief Ladder* (Geneva, 2010). Available from www.who.int/cancer/palliative/painladder/en/.

[71] O. Gureje and others, "Persistent pain and well-being: a World Health Organization study in primary care", *JAMA*, vol. 80 (1998), pp. 147-151.

from severe to moderate pain, where palliative care essentially is unavailable, said they would prefer to die than continue living with untreated, severe pain.[72]

44. Emergency obstetric procedures and management of epilepsy also require use of scheduled medications, and remain inadequately resourced. Post-partum haemorrhage results in over 100,000 maternal deaths annually.[73] Oxytocin and ergometrine, two controlled drugs used in obstetric procedures, are difficult to access yet reduce the risk of severe post-partum bleeding by more than half.[73] Similarly, around 75 per cent of people with epilepsy in developing countries and up to 90 per cent of patients with epilepsy in Africa do not receive treatment with essential medicines, including phenobarbital, partly because it is a controlled substance.[74]

45. Compliance with procedural requirements associated with stocking, supplying and prescribing scheduled medications can be burdensome for health-care institutions and workers, creating a barrier to supply of these medications. Such procedures, for example, include restrictive licensing of controlled medicines within health-care institutions. In some countries, it is reported that only "Level 1" hospitals are allowed to prescribe opioids.[75] Regulations also limit the substances a doctor may prescribe, or the amount that can be prescribed. Certain States require health-care workers to obtain special licences to prescribe morphine, in addition to their professional licences.[76] Restrictive laws are a particular problem in the cases of methadone and buprenorphine, drugs used for OST. In some States use of these drugs is outlawed.[77]

46. Many myths exist surrounding the use of controlled drugs: that they lead to addiction, do not treat pain adequately, or that chronic or terminal pain is untreatable. Health-care workers themselves often are undereducated in palliative care and feel uncomfortable prescribing opioid analgesics for fear they will lead to dependence,[75] to the contrary conclusions of scores of studies.[78] Where inadequate training is the norm, health-care workers may be unsure of the legal implications of their prescribing practices — especially in relation to patients who use illicit drugs — and may avoid prescribing these medications altogether, which further limits the supply of essential medications.

47. Economic affordability is a central component of the right-to-health requirement of accessibility. Controlled medicines need not be made available for free; rather, at an affordable cost. Despite this, even medicines that can be manufactured at low cost are not necessarily affordable for consumers, because drug producers incur significant regulatory costs that are passed on to consumers within the market price of the drug. For instance, Cipla, a generic manufacturer in India,

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[72] Human Rights Watch, *Unbearable Pain: India's Obligation to Ensure Palliative Care* (New York, 2009), pp. 18-20.

[73] WHO, Fact sheet No. 336, "Medicines: access to controlled medicines (narcotic and psychotropic substances)", June 2010, p. 2. Available from www.who.int/mediacentre/factsheets/fs336/en/index.html.

[74] Ibid., p. 1.

[75] Human Rights Watch, *Please, do not make us suffer anymore…:Access to Pain Treatment as a Human Right* (New York, 2009), p. 25.

[76] Ibid., p. 30.

[77] Open Society Institute, *At What Cost?: HIV and Human Rights Consequences of the Global War on Drugs* (New York, 2009), p. 84.

[78] WHO, Achieving Balance in National Opioids Control Policy (Geneva, 2000), pp. 8 and 9.

produces 10 mg morphine tablets sold wholesale for US$ 0.017 each, yet the median cost of a month's supply of morphine in low- and middle-income countries is $112, as compared to $53 for industrialized countries.[79] Additionally, non-generic medicines frequently are promoted for use over cheaper, equally safe and effective generic counterparts. Branded drugs generally are more expensive and, therefore, unaffordable for large parts of the population, especially vulnerable groups, such as people who use drugs and people living with HIV.

VI. A human rights-based approach to drug control

48. A human rights-based approach to drug control must be adopted as a matter of priority to prevent the continuing violations of rights stemming from the current approaches to curtailing supply and demand, and to move towards the creation of a humane system that meets its own health-related objectives. Currently, there is a lack of coordination and discussion between the actors involved in drug control and human rights at the international level. Law enforcement approaches are ingrained institutionally in the international drug control regime, as drug control is housed within UNODC, which leads the United Nations efforts on organized crime. This association between law enforcement and drug control, in part, precludes adoption of a human rights-based approach and interaction with the human rights bodies of the United Nations.

49. The ineffectiveness of the current international drug control system must be understood, and reform undertaken at all policymaking levels. National governments should implement harm reduction programmes and policies, decriminalize or de-penalize drug use and possession, and reform regulations concerning essential medicines. United Nations drug control bodies must ensure system-wide coherence by adopting a human rights-based approach to drug control, which necessarily requires recognition of international human rights as central to their operations, and these changes in the international system should also guide and legitimize domestic reforms.

A. Harm reduction and evidence-based treatment

50. Harm-reduction interventions aim to reduce the harms associated with the use of psychoactive drugs, without necessarily discouraging use,[80] and may operate within restrictive legal regimes. These interventions include, inter alia, needle and syringe programmes, prescription of substitute medications, drug-consumption rooms, route-transition interventions (interventions promoting non-injecting routes of drug administration), overdose prevention practices, and outreach and education programmes.

51. Needle and syringe programmes involve provision of sterile injection equipment to injecting drug users. The World Health Organization has endorsed the

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[79] S. Burris and C. Davis, "A Blueprint for Reforming Access to Therapeutic Opioids: Entry Points for International Action to Remove the Policy Barriers to Care", Centers for Law and the Public's Health: A Collaborative at the Johns Hopkins and Georgetown Universities (2008), p. 18

[80] International Harm Reduction Association (IHRA), *What is harm reduction?* (London, 2010), p. 1.

use of such programmes, noting that "compelling evidence" exists that they reduce HIV infections substantially, in a cost-effective manner, without any major negative consequences.[81] The use of needle and syringe programmes is consistent with standard public health principles, in that elimination of a vector (in this case, the contaminated needles) reduces transmission of vector-driven disease.[82]

52. Opioid substitution therapy (OST) is an evidence-based treatment approach, involving prescription of substitute medications for opioid dependence, such as methadone or buprenorphine. OST decreases the prevalence of injecting drug use and sharing of injecting equipment, thus reducing the risk of contracting HIV and other blood-borne viruses.[83] Global availability of OST could reduce cases of new HIV infections by over 100,000,[84] reduce significantly the prevalence of other blood-borne diseases, and reduce overdose deaths from opioid use by nearly 90 per cent.[84] Where OST is not available, a higher incidence of overdose often is observed following drug dependence treatment, owing to the individual's decreased tolerance for the drug.[85] Additionally, numerous studies indicate that pharmacological support is effective at managing withdrawal from opioids[86] and preventing relapse into drug use.[87]

53. Interventions such as education programmes are also designed to minimize harm to individuals who use drugs. Currently, little information exists on their effectiveness, often because they are integrated into other programmes, but they are frequently utilized.[88] One meta-analysis concluded that educational programmes result in risk-reducing behaviour change among people who use drugs, but results varied based on programme design.[89] Outreach programmes are used to contact people who use drugs in their own communities, and to provide information, referral to medical testing and services, among other activities. A reduction in risk behaviour of around 27 per cent has been observed following contact with outreach services.[90]

54. Interventions such as first-aid training and administration of Naloxone (an opioid receptor antagonist used to reverse depression of the central nervous system

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[81] WHO, *Effectiveness of sterile needle and syringe programming in reducing HIV/AIDS among injecting drug users* (Geneva, 2004), p. 28.

[82] S. Burris and others, "Physician Prescribing of Sterile Injection Equipment to Prevent HIV Infection: Time for Action", *Annals of Internal Medicine*, vol. 133, No. 3 (2000), p. 219.

[83] L. Gowing and others, "Substitution treatment of injecting opioid users for prevention of HIV infection (Review)", *The Cochrane Library*, issue 4 (2008), pp. 27-29.

[84] WHO, Briefing Note 2007: *Access to Controlled Medications Programme* (Geneva, 2007), p. 1.

[85] Eurasian Harm Reduction Network, *The impact of drug policy on health and human rights in Eastern Europe: 10 years after the UN General Assembly Special Session on Drugs* (Vilnius, 2009), p. 18.

[86] See L. Gowing and others, "Alpha2-adrenergic agonists for the management of opioid withdrawal", *The Cochrane Library*, issue 3 (2009).

[87] L. Gowing and others, "Substitution treatment of injecting opioid users for prevention of HIV infection (Review)", *The Cochrane Library*, issue 4 (2008).

[88] N. Hunt, "A review of the evidence-base for harm reduction approaches to drug use", p. 30. Available from www.forward-thinking-on-drugs.org/review2-print.html.

[89] J. E. Cross and others, "The Effectiveness of Educational and Needle Exchange Programs: A Meta-analysis of HIV Prevention Strategies for Injecting Drug Users" *Quality & Quantity*, vol. 32, No. 2 (1998), p. 176.

[90] A. Ritter and J. Cameron, "A review of the efficacy and effectiveness of harm reduction strategies for alcohol, tobacco and illicit drugs" *Drug and Alcohol Review*, vol. 25, No. 6 (2006), p. 615.

in cases of opioid overdose) are also used to minimize the harm associated with drug overdose, as is the use of drug-consumption rooms, where individuals can use drugs in a supported environment. The potential benefits of drug-consumption rooms include prevention of disease transmission and reduced venous damage, as well as encouraging entry to treatment and other services. Evidence exists that drug-consumption rooms have contributed to reductions in overdose rates, and increased access to medical and social services.[91]

55. Article 12 (c) of the International Covenant on Economic, Social and Cultural Rights obliges State Parties to take steps to prevent, treat and control epidemics. As HIV has reached epidemic proportions within communities of people who use drugs, particularly in prisons, States are explicitly required to take direct action in this regard. Article 15, paragraph 1 (b), of the Covenant also states that everyone has the right to enjoy the benefits of scientific progress. As a significant body of evidence exists regarding the effectiveness of harm-reduction programmes and policies, States Parties are obliged to implement such interventions, but they remain underutilized worldwide. Currently, 93 countries and territories support a harm-reduction approach.[92] As of 2009, needle and syringe programmes had been implemented in 82 countries, and OST in 70 countries, with both interventions available in 66 countries.[93] However, needle and syringe programmes have been confirmed to be absent in 55 countries where injecting drugs are used, and OST in 66 such countries.[94] It is particularly disturbing that OST is unavailable in 29 countries throughout Africa and the Middle East, especially in the light of the HIV burden throughout Africa.[94]

1. HIV/AIDS

56. Drug laws and policies impact on HIV control because of the dynamics of drug usage: in particular, the sharing of needles, through which HIV can be transferred. Approximately one in 10 new HIV infections worldwide result from injecting drug use, and up to 90 per cent of infections occur among people who inject drugs in regions such as Eastern Europe and Central Asia.[95] Where harm-reduction interventions are not implemented, HIV prevalence among people who inject drugs can rise to 40 per cent or greater within a year or two of introduction of the virus into their communities.[96]

57. The risk of virus transmission through needle sharing can be addressed through the principles of harm reduction. Implementation of needle and syringe programmes strongly correlates with a reduction in risk behaviours, which predispose people who inject drugs to HIV infection.[97] Other benefits associated

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[91] N. Hunt, "A review of the evidence-base for harm reduction approaches to drug use", pp. 31 and 32.

[92] IHRA, *The Global State of Harm Reduction 2010* (London, 2010), p. 8.

[93] B. Mathers and others, "HIV prevention, treatment and care services for people who inject drugs: a systematic review of global, regional and national coverage", *The Lancet,* vol. 375 (2010), pp. 1018 and 1019.

[94] Ibid., pp. 1019-1021.

[95] WHO (Europe), *Status Paper on Prisons, Drugs and Harm Reduction* (Copenhagen, 2005), p. 3.

[96] Ibid., p. 5.

[97] A. Wodak and A. Cooney, "Do Needle Syringe Programs Reduce HIV Infection among Injecting Drug Users: A Comprehensive Review of the International Evidence", *Substance Use & Misuse* (2006), vol. 41, Nos. 6-7, p. 792.

with such programmes include increased entry into HIV-treatment programmes.[98] However, current coverage of needle and syringe programmes, OST and antiretroviral therapy (ART) services is insufficient to prevent HIV transmission in the vast majority of countries where people use injecting drugs.[99] Funding to ensure universal access to HIV prevention services for people who inject drugs currently stands at around one twentieth of that required.[100]

58. The United Nations has declared that outreach activities, needle and syringe programmes and evidence-based drug dependence treatment (including OST) should be implemented to minimize the risk of transmission of HIV among those who use drugs.[101] The Committee on Economic, Social and Cultural Rights recognized that harm reduction forms a central part of national responses to illicit drug dependence and it has made recommendations to States Parties. The Human Rights Council, in resolution 12/27, also recognized the need for "a comprehensive package of services for injecting drug users, including harm-reduction programmes in relation to HIV".[102]

2. Places of detention

59. States are obliged to respect the right to health by refraining from denying equal access for all persons, including prisoners or detainees, to preventive, curative and palliative health services.[103] Many States have begun to implement harm-reduction programmes within treatment facilities because prior punitive regimes have resulted in the most rapidly increasing rates of HIV incidence in the world.[104] Nevertheless, needle and syringe programmes currently are available only in places of detention in 10 countries, and OST is available in at least one prison in fewer than 40 countries.[105]

60. The International Covenant on Economic, Social and Cultural Rights imposes a number of immediate obligations on States Parties, including that they guarantee that rights will be exercised without discrimination.[106] If harm-reduction programmes and evidence-based treatment are made available to the general public, but not to persons in detention, that contravenes international law. Indeed, because of the health risks associated with incarceration, the Special Rapporteur considers that greater efforts may be required inside prisons to meet public health objectives. In the context of HIV and harm reduction, this demands implementation of harm-reduction services in places of detention even where they are not yet available in the

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[98] Ibid., p. 799.

[99] Mathers and others, "HIV prevention", p. 1025.

[100] G. V. Stimson and others, "Three Cents a Day is Not Enough: Resourcing HIV-Related Harm Reduction on a Global Basis" (International Harm Reduction Association, 2010).

[101] Administrative Committee on Coordination (ACC) Subcommittee on Drug Control (2000). *Preventing the Transmission of HIV among Drug Abusers: A position paper of the United Nations System*. Annex to the report of eighth session of the ACC Subcommittee on Drug Control (28 and 29 September 2000), paras. 3-10.

[102] A/HRC/12/50, sect. I.

[103] CESCR, General Comment No. 14 (E/C.12/2000/4), para. 34.

[104] Open Society Institute, "At What Cost? HIV and Human Rights Consequences of the Global 'War on Drugs'" 2009, p. 81

[105] IHRA, *Global State of Harm Reduction 2010* (London, 2010), p. 105.

[106] E/C.12/2000/4, para. 30.

community, as the principle of equivalence is insufficient to address the epidemic among prisoners.[107]

61. The 2009 Madrid Recommendation notes that there is "overwhelming evidence" that health-protection measures, including harm-reduction measures, are effective in prisons.[108] The Madrid Recommendation states that treatment programmes for people who use drugs, as well as harm-reduction measures, including needle and syringe programmes, are urgently needed in all prison systems.[109] Drug-dependence treatment is also noted to be "highly effective in reducing crime": treatment and care within prison, or as alternatives to imprisonment, reduce rates of relapse, HIV transmission and reincidence in crime.[110] Effective drug-dependence treatment thus protects not only the individual, but society at large, and combats the negative cycle of recidivism that exposes other detainees to risk. As harm-reduction programmes are cost-effective and relatively easy to operate in closed settings, they should be implemented within places of detention as a matter of urgency.

B. Decriminalization and de-penalization

62. The Special Rapporteur considers that the continuing imposition of criminal penalties for drug use and possession perpetuates many of the major risks associated with drug use. He advocates for consideration of less restrictive approaches to drug control, including decriminalization or de-penalization. Decriminalization of drug use cannot simply be equated with *legalization* of drug use. When decriminalized, drug use and possession can remain legally prohibited, but criminal penalties for such offences either are not applied at all or only minor penalties are given. Decriminalization generally entails complete removal of criminal punishment for the conduct in question (administrative penalties may be applied instead), whereas de-penalization requires removal of custodial sentences, although the conduct remains a criminal offence.[111] Legalization, by contrast, involves no prohibitions on the relevant conduct.

63. The international drug control treaties include space for a number of good-faith interpretations that allow for domestic legislative reform,[112] even in the absence of significant changes to the international drug control regime. For instance, article 3, para. 2 of the 1988 United Nations Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances provides that obligations to criminalize possession for personal consumption are subordinate to the State's constitutional principles and the concepts of its legal system. For example, the Supreme Court of

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[107] See R. Lines, "From equivalence of standards to equivalence of objectives: the entitlement of prisoners to health care standards higher than those outside prisons", *International Journal of Prisoner Health*, vol. 2, No. 4 (2006), pp. 269-280.

[108] WHO (Europe), *The Madrid Recommendation: health protection in prisons as an essential part of public health* (Madrid, 2009), p. 3.

[109] Ibid., p. 4.

[110] UNODC and WHO, *Principles of Drug Dependence Treatment: Discussion Paper* (Geneva, 2008), p. 14.

[111] G. Greenwald, *Drug Decriminalization in Portugal: Lessons for Creating Fair and Successful Drug Policies* (Cato Institute, Washington, D.C., 2009), p. 2.

[112] G. Harris, "Decriminalisation: pushing the limits of drug control", International Harm Reduction Association Conference, Liverpool, 27 April 2010.

Argentina recently held that application of criminal sentences for possession of marijuana for personal use is unconstitutional. Subsequently, Argentina has taken legislative measures to decriminalize personal use of drugs. Mexico also recently decriminalized possession of small amounts of drugs for personal use, and both countries have been criticized by the International Narcotics Control Board, particularly on the grounds that the amendments send "the wrong message to the general public".[113]

64. Moreover, in 2001, Portugal decriminalized purchase, possession and usage of all illicit drugs for personal use, instead characterizing them as administrative offences.[114] That law allows for imposition of pecuniary or non-pecuniary penalties, and there is a provision for sanctions to be suspended, should the offender undertake treatment. In contrast to the International Narcotics Control Board's reaction to Argentina and Mexico, decriminalization to this extent has been deemed consistent with the 1988 Convention.[115] Decriminalization generally was perceived as the best option for minimizing drug-related problems in Portugal, largely through de-stigmatizing drug use and bringing a higher proportion of drug users into treatment, rather than a communication to the public that drug use was condoned.[116]

65. Several other States have de-penalized various forms of drug use and possession. This has occurred either through legislation to that effect, or de facto de-penalization, whereby drug laws are not enforced strictly. Spain maintains criminal sanctions for drug use, although persons tried are never imprisoned for drug consumption alone.[116] In the Netherlands and Germany, possession of drugs for personal use remains de jure unlawful, but punishment is not imposed for breaches of these laws.[117] This, however, is obviously an inadequate solution at best.

66. Decriminalization and de-penalization have the potential to diminish the risks associated with drug use and increase participation of people who use drugs in drug treatment. In Portugal, drug use decreased in absolute terms across key demographic categories following decriminalization, and both drug-related mortality and new cases of HIV among people dependent on drugs decreased.[118] The number of people undertaking substitution therapy also rose from 6,040 to 14,877 between 1999 and 2003.[119]

67. It should be noted that, for example in Portugal, decriminalization occurred alongside other efforts, including significant expansion of drug treatment programmes, drug education and refocusing of police efforts on interruption of trafficking operations.[119] This demonstrates how legislative change alone is insufficient to minimize significantly the harms occurring with drug use. Where decriminalization occurs alongside treatment, education and other interventions implemented to the required scale — for instance, to contain the spread of blood-

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[113] INCB, *Report of the International Narcotics Control Board for 2009* (E/INCB/2009/1), pp. 68 and 75.

[114] Article 2(1), Decree-Law No. 183/2001 of 21 June 2001, Portugal.

[115] INCB, *Report of the International Narcotics Control Board for 2004* (E/INCB/2004/1), p. 80.

[116] C. Hughes and A. Stevens, "What can we learn from the Portuguese decriminalisation of illicit drugs?" *British Journal of Criminology*, forthcoming.

[117] M. Jelsma, "Salir de la oscuridad", *Newsweek Argentina*, 19 August 2009.

[118] Ibid., pp. 15-17.

[119] C. Hughes and A. Stevens, "The Effects of Decriminalization of Drug Use in Portugal", *The Beckley Foundation Drug Policy Programme*, Briefing Paper 14 (2007), p. 2.

borne viruses — the right to health of all members of society is realized most effectively.

68. De-penalization of certain drug offences also would result in decreased incarceration rates, in turn decreasing the health risks that are associated with imprisonment. Excessive penalization can also lead to overcrowding and poor conditions in prisons, and has itself provided an impetus for softening some drug use laws.[120] De-penalization recently has occurred in Brazil, where prison sentences were removed for possession of drugs for personal use and replaced with educational programmes.[121]

69. In addition to legislative change, the importance of re-education and awareness-raising among law enforcement personnel cannot be underestimated, particularly because of the risk created by strict policing practices. For instance, the prevalence of HIV among people who inject drugs was recorded as significantly higher in Edinburgh in the 1980s, where police aggressively enforced laws banning needle possession, as compared to nearby Glasgow, where such strict enforcement was not taken.[122] Any efforts to decriminalize or de-penalize drug use or possession must be coupled with appropriate strategies to ensure that the fear and stigma that were reinforced through excessive policing are ameliorated.

C. Use of human rights indicators and guidelines

70. Formulation of international guidelines concerning implementation of the international drug control treaties would address in detail the relationship between drug control efforts and human rights, and allow States to determine whether their efforts are consistent with a right-to-health approach. Such guidelines should seek to highlight the vulnerability of marginalized groups, such as people who use drugs and people living with HIV, who are most at risk of human rights violations as a result of drug control regimes. These guidelines must be developed in an inclusive, participatory and transparent consultation process with affected communities. International guidelines used to direct policy and programmes at a national level have already been developed for HIV and counter-terrorism, which outline how human rights standards apply in each context and list practical measures that should be undertaken by States in responding to those issues in accordance with a rights-based approach.

71. Over the last 10 years, this procedure has also canvassed the use of health indicators as part of a human rights-based approach to health.[123] A human rights-based approach is one that requires “effective, transparent and accessible monitoring and accountability mechanisms”.[123] Human rights-based indicators are being used in many areas, including poverty reduction, development and other critical areas, to ensure that States fulfil all obligations created by the various human rights. The former Special Rapporteur posited three categories of indicators: structural, process and outcome indicators. A structural indicator, generally framed as a yes/no answer, asks whether a key structure or mechanism is in place, whereas process and outcome

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[120] Ibid., p. 9.

[121] See Law No. 11,343/2006, article 28.

[122] R. MacCoun and P. Reuter, “Harm Reduction in Europe”, *Drug war heresies: learning from other vices, times and places* (Cambridge, 2001), p. 266.

[123] See E/CN.4/2006/48, sect. II.

indicators utilize benchmarks that usually are measured by a percentage or number, and therefore require more sophisticated research and analysis.[124] Process indicators measure State efforts to realize the right to health, whereas outcome indicators measure the impact of such interventions on the health of populations. These indicators create a standard to which States may be held, allowing States to measure their progressive achievements, and for deficiencies to be demonstrated empirically when they occur.

72. The Special Rapporteur suggests that indicators similar to those detailed below be developed by the relevant international organizations:

(a) Structural:

(i) Availability of OST, needle and syringe programmes and other harm-reduction interventions;

(ii) State adoption of an essential medicines list;

(iii) Availability of those essential medicines;

(iv) Implementation of diversion or similar legislation for people who are dependent on drugs who encounter the criminal justice system;

(b) Process:

(i) Percentage of detention centres in which harm-reduction interventions are implemented;

(ii) Percentage of people who use drugs receiving antiretroviral therapy (where applicable);

(iii) Percentage of people who are dependent on drugs receiving appropriate treatment (as outlined by UNODC/WHO);

(c) Outcome:

(i) Percentage of people who use drugs who are infected with HIV;

(ii) Percentage of people in places of detention who are infected with HIV.

D. Alternative regulatory frameworks for drug control

73. The Special Rapporteur considers that there is a need in the long term to consider alternatives to the current drug control system. One such alternative model may be the Framework Convention on Tobacco Control, in which certain controlled medicines would be regulated in a manner similar to tobacco. The purpose of the Framework Convention is to reduce the social, environmental and public health harms of tobacco smoke through creation of a framework by which global tobacco use may be decreased continually. It represents a paradigm shift in developing a regulatory strategy to address addictive substances, which protects the rights of people who use and are dependent on drugs while minimizing associated harms. A new regulatory framework concerning drugs other than tobacco would require assessment of the scientific evidence of a drug's effects on the individual and the

[124] A/58/427, para. 25.

public, the public health and human rights effects of each controlled drug, and inclusion into the scheme would occur on a case-by-case basis.

74. The non-prices measures of the Framework Convention on Tobacco Control provide the best examples of the protections and regulations that may replace the existing enforcement-based framework. Such measures include regulation of drug content, education and awareness-building, and measures concerning dependence reduction and cessation. Implementation of these measures would secure the right to health by, inter alia, ensuring supply of unadulterated drugs, increasing individual and community awareness to minimize risk, and ensuring access to appropriate treatment, where necessary. There generally are high levels of implementation among Parties to the Framework Convention on Tobacco Control on nearly all of these measures, suggesting similar possibilities for currently controlled drugs.

75. The proposed framework additionally would allow traditional, cultural use of drugs, whose public health impact has been shown to be very limited, such as coca leaves in Bolivia and various forms of cannabis in India. The existing regime has deprived millions of people of their livelihoods and denied traditional usage of drugs because of prohibitions on cultivation and extremely harmful eradication methods used to limit production. These sanctions are unwarranted and unhelpful in restricting drug use.

VII. Recommendations

76. **Member States should:**

- **Ensure that all harm-reduction measures (as itemized by UNAIDS) and drug-dependence treatment services, particularly opioid substitution therapy, are available to people who use drugs, in particular those among incarcerated populations.**
- **Decriminalize or de-penalize possession and use of drugs.**
- **Repeal or substantially reform laws and policies inhibiting the delivery of essential health services to drug users, and review law enforcement initiatives around drug control to ensure compliance with human rights obligations.**
- **Amend laws, regulations and policies to increase access to controlled essential medicines.**

77. **The United Nations drug control bodies should:**

- **Integrate human rights into the response to drug control in laws, policies and programmes.**
- **Encourage greater communication and dialogue between United Nations entities with an interest in the impact of drug use and markets, and drug control policies and programmes.**
- **Consider creation of a permanent mechanism, such as an independent commission, through which international human rights actors can contribute to the creation of international drug policy, and monitor national implementation, with the need to protect the health and human**

rights of drug users and the communities they live in as its primary objective.

- **Formulate guidelines that provide direction to relevant actors on taking a human rights-based approach to drug control, and devise and promulgate rights-based indicators concerning drug control and the right to health.**
- **Consider creation of an alternative drug regulatory framework in the long term, based on a model such as the Framework Convention on Tobacco Control.**