OVER VIEW

Human Rights and Drug Control Policy

In many countries around the world, drug control efforts result in serious human rights abuses: torture and ill treatment by police, mass incarceration, extrajudicial killings, arbitrary detention, denial of essential medicines and basic health services. Drug control policies, and accompanying enforcement practices, often entrench and exacerbate systematic discrimination against people who use drugs, and impede access to controlled essential medicines for those who need them for therapeutic purposes. Local communities in drug-producing countries also face violations of their human rights as a result of campaigns to eradicate illicit crops, including environmental damage, displacement and damage to health from chemical spraying.

Briefings:

1. Harm Reduction
2. Drugs, Criminal Laws and Policing Practices
3. Harm Reduction in Places of Detention
4. Compulsory Drug Treatment
5. Controlled Essential Medicines
6. Crop Eradication

These abuses are widespread and systematic. They are cause for considerable concern in themselves, but they are also impeding an effective response to the AIDS epidemic by denying people who use drugs access to proven, effective HIV prevention, care, and treatment services and by contributing to at least one million people living with HIV/AIDS going without adequate treatment to address moderate to severe pain.

It is not enough to apply the drug conventions in a vacuum. Every UN Member state has ratified at least one of the core human rights treaties. Most have ratified many more. Every state is bound by UN Charter obligations in relation to human rights, and every state is bound by customary international law. As such, these issues raise considerable legal and strategic questions for states seeking to live up to their international human rights and drug control obligations.

Increasingly, human rights monitors, mechanisms and NGOs have begun to focus on drug policies and their impact on human rights protections, but this rarely happens in a connected or thematic way. These briefing papers are intended to provide a basic overview of some of the core human rights issues related to drug control efforts and to show how they interconnect, and to spark a discussion of how international human rights law can be engaged to address a range of human rights concerns raised by drug enforcement laws, policies, and practices.

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INTERNATIONAL HARM REDUCTION ASSOCIATION

Briefing 1

Human Rights and Drug Policy

Harm Reduction

"State Parties have obligations under international law and in particular under Article 12 of the International Covenant on Economic, Social and Cultural Rights (ICESCR) to prevent epidemics. Therefore, states have an obligation under international law to pursue harm reduction strategies."

—Anand Grover[1]

UN Special Rapporteur on the right to the highest attainable standard of health

Context: Injecting drug use, HIV/AIDS and the 'war on drugs'

It is estimated that 15.9 million people inject drugs[2] in 158 countries and territories around the world.[3] The overwhelming majority lives in low- and middle-income countries. Unsafe injecting practices put people who inject drugs at high risk of HIV transmission. Outside of sub-Saharan Africa, up to 30% of all HIV infections occur through injecting drug use. In some countries, in particular in Central and Eastern Europe and East Asia, injecting drug use is the primary driver of HIV epidemics. In some places up to 80% of people living with HIV are likely to have acquired the virus through unsafe injecting.[4] Evidence suggests that more than three million people who inject drugs are living with HIV.[5]

What is harm reduction?[6]

The harm reduction approach to drugs is based on a strong commitment to public health and human rights, and benefits people who use drugs, their families and the community. Harm reduction, in essence, refers to policies, programs and practices that aim to reduce the harms associated with the use of psychoactive drugs without necessarily requiring the cessation of use. Harm reduction complements approaches that seek to prevent or reduce the overall level of drug consumption but accepts that many people who use drugs are unable or unwilling to stop. It also accepts that some people who use drugs do not need treatment. There is a need to provide people who use drugs with options that help to minimize risks from continuing to use drugs, and of harming themselves or others.

Examples of harm reduction interventions (see also briefings no. 3 and 5)

- Needle and Syringe Programs (NSPs)
- Substitute Medication Prescribing (e.g. opioid substitution therapy)
- Overdose Prevention (e.g. Naloxone, first aid training)
- Drug Consumption Rooms
- Route Transition Interventions[7]
- Outreach and Peer Education

Both needle and syringe exchange programs and opioid substitution therapy (OST) are essential components of the comprehensive HIV prevention, treatment and care package for people who inject drugs, as defined by UNAIDS, UNODC and WHO.[8]

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Harm Reduction in Policy and Practice Worldwide[9]

Despite the overwhelming evidence in favor of harm reduction as an effective HIV prevention strategy, the global state of harm reduction is poor. This is especially true in countries where harm reduction services are needed most urgently:

84 countries support harm reduction in policy or practice
74 have an explicit supportive reference to harm reduction in national policy documents
77 have needle and syringe exchange
10 have needle and syringe exchange in prisons
65 have opioid substitution therapy
37 have opioid substitution therapy in prisons
8 have drug consumption rooms

According to research by IHRA, there are at least 76 countries where injecting drug use has been documented and where no harm reduction services are available. Moreover, these figures are top line and do not indicate the scope, quality or coverage of services. In many countries, needle and syringe exchanges are run entirely by NGOs with, at best, grudging acceptance by the government, and, even though they are legal, are targeted by police (See Briefing No. 2). **Coverage levels sufficient to avert or reverse HIV epidemics have thus far only been implemented in parts of Western Europe, Australia and New Zealand.**

In the region of **South-East Asia**, only 3% of people who inject drugs have access to harm reduction programs. In East Asia, this figure is 8%. Needle and syringe exchange programs and opioid substitution therapy (OST) sites are currently limited to pilot programs in the majority of countries, reaching very small numbers.

Central and Eastern Europe and Central Asia witnessed the fastest growing HIV epidemics in the world. As a response to rapidly expanding HIV epidemics, almost all states in the region have needle and syringe programs, and the majority of states (23 of 29) prescribe OST for drug dependence. Russia, however, is home to around two million people who inject drugs, but the use of OST is still prohibited.

While injecting is rare in the **Caribbean**, recent research highlights a link between non-injecting drug use and sexual HIV transmission in several Caribbean countries, with HIV prevalence estimates among crack cocaine smoking populations reaching those found among injecting populations elsewhere. This linkage is not being adequately addressed and national drug and HIV policies remain largely unrelated in the region.

In **Latin America,** needle and syringe programs are available in five countries, although the vast majority operate in Brazil and Argentina. Mexico, with substantially more heroin users than other Latin American countries, is the only state which prescribes OST, although coverage is low.

In the **Middle East and North Africa,** six countries, including Iran, have needle and syringe programs and three have OST, although none have responses sufficient to meet the need. Across the region there is a low awareness of risks associated with injecting drug use. Few NGOs are working on harm reduction in the region, and in several countries restrictions on NGOs further limit the harm reduction response from civil society.

Although data on drug use in the region are limited, injecting has been reported in 31 of 47 **sub-Saharan African states.** Where data are available, they suggest high HIV prevalence among people who inject drugs. A Kenyan study, for example, found that six of every seven female injectors were living with HIV. Responses to HIV in the region currently include little focus on people who inject drugs. Mauritius, where an estimated 17,000—18,000 people inject drugs, is the only country where needle and syringe programs are operating.

Funding for harm reduction is very low globally and is neither representative of what is needed to address the HIV epidemic among injecting drug users, nor proportionate to injection-driven HIV transmission versus sexual transmission.[10]

In many countries, harm reduction is further hampered by criminal laws, disproportionate penalties and law enforcement practices that can drive people away from the health and harm reduction services that do exist and can lead to more risky forms of drug use. (See Briefing no. 2).

When people are imprisoned for drug related offenses, they often find that harm reduction services are unavailable to them. Only ten countries have needle and syringe exchange in prisons, and only 37 have OST. Prisons are concentrated risk environments for HIV transmission. As is regularly noted, good prisoner health is good public health. The absence of harm reduction in so many prisons is very worrying (See Briefing no. 3).

International Support[11]

Aside from support in the form of overwhelming scientific consensus,[12] harm reduction has been endorsed twice at the General Assembly, at the Economic and Social Council and recently at the Human Rights Council in the context of HIV/AIDS.[13]

These interventions are considered best practice in relation to HIV prevention among injecting drug users by every relevant UN agency, including the UN Office on Drugs and Crime, WHO, UNICEF, UNDP and UNAIDS.[14] The High Commissioner for Human Rights, Navanethem Pillay, has also expressed her office's support to harm reduction, stating that *"A harm reduction approach is the most effective way of protecting rights, limiting personal suffering, and reducing the incidence of HIV… We cannot deny that those suffering from addiction require medical care."*[15]

Harm Reduction and Human Rights

The right to health

The Committee on Economic, Social and Cultural Rights has, in recent sessions, recommended that states parties scale up their harm reduction programs in order to meet their obligations under article 12 of the Covenant. In relation to **Ukraine** in 2007, the Committee stated that it was "*gravely concerned at…the limited access by drug users to substitution therapy,*" and recommended that the state party *"make drug substitution therapy and other HIV prevention services more accessible for drug users."*[16]

In its Concluding Observations on **Tajikistan** in 2006, the Committee recommended *"that the State party establish time-bound targets for extending the provision of free testing services, free treatment for HIV and harm reduction services to all parts of the country."*[17]

Both the current and former Special Rapporteurs on the Right to the Highest Attainable Standard of Health have spoken out strongly in favor of harm reduction, in both speeches and following country missions.[18] As clearly stated by the former Special Rapporteur, Professor Paul Hunt, *"In seeking to reduce drug-related harm, without judgement, and with respect for the inherent dignity of every individual, regardless of lifestyle, harm reduction stands as a clear example of human rights in practice. What began as a health-based intervention in response to HIV must today be recognised as an essential component of the right to the highest attainable standard of health for people who inject drugs."*[19]

Freedom from cruel inhuman and degrading treatment

The Special Rapporteur on Torture has called specifically for harm reduction in places of detention.[20] (See also Briefing No. 3) He argued that "there can be no doubt that withdrawal symptoms can cause severe pain and suffering if not alleviated by appropriate medical treatment" [21] and concluded that "denial of medical treatment and/or absence of access to medical care in custodial situations may constitute cruel, inhuman or degrading treatment or punishment and is therefore prohibited under international human rights law."[22] He also recommended that "needle and syringe programmes in detention should be used to reduce the risk of infection with HIV/AIDS."[23]

The Special Rapporteur urged the Human Rights Council to address the tensions between drug control and human rights obligations. [24]

The rights of the child

Article 33 of the Convention on the Rights of the Child requires that States Parties "take all appropriate measures, including legislative, administrative, social and educational measures, to protect children from the illicit use of narcotic drugs and psychotropic substances as defined in the relevant international treaties..."

In its General Comment No. 3 on HIV/AIDS, the Committee on the Rights of the Child said, "Injecting practices with unsterile equipment further enhances the risk of HIV transmission. The Committee notes that greater understanding is needed of substance-use behaviours among children, including the impact that neglect and violation of the rights of the child has on these behaviours. In most countries, children have not benefited from pragmatic HIV prevention programmes related to substance use, which even when they do exist have largely been targeted at adults."[25]

The Committee has since called for *"the provision of necessary evidence-based support, recovery and reintegration services to all children affected by substance abuse…aimed at effectively reducing the harmful consequences of such abuse."*[26]

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4 Joint United Nations Programme on HIV/AIDS and World Health Organization, "AIDS epidemic update," 2007.
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17 UN Doc No E/C.12/TJK/CO/1 para 70.
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25 N Committee on the Rights of the Child (CRC), *CRC General Comment No. 3: HIV/AIDS and the Rights of the Child*, 17 March 2003, CRC/GC/2003/3, para. 35
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Briefing 2

Human Rights and Drug Policy

Drugs, Criminal Laws and Policing Practices

Too often, drug users suffer discrimination, are forced to accept treatment, marginalized and often harmed by approaches which over-emphasize criminalization and punishment while under-emphasizing harm reduction and respect for human rights.

—UN High Commissioner for Human Rights, 2009[1]

Governments have a duty under international law to take steps to reduce supply of and demand for controlled drugs. In doing so, they must ensure that these efforts are balanced with obligations to ensure adequate availability of controlled drugs for medical purposes, and that these steps are consistent with states' human rights obligations. Unfortunately, punitive approaches have taken priority in law, practice and funding in the response to drug use and drug dependence all over the world. Criminal laws, disproportionate penalties and law enforcement practices have resulted in negative health outcomes and have affected a wide range of other human rights.

Criminal laws, policies and law enforcement approaches

Criminal laws relating to drug use and possession for personal use

In almost every country in the world, possession of drugs for personal consumption is a crime. In many, drug use itself is a crime. The implications for those who have a dependency—a chronic, relapsing medical condition—are particularly serious. Individuals have a right to obtain lifesaving health services without fear of punishment or discrimination. But in some countries, many people who inject drugs do not carry sterile syringes or other injecting equipment, even though it is legal to do so, because possession of such equipment can mark an individual as a drug user and expose him or her to punishment on other grounds.[2] Many do not seek treatment or attend harm reduction services, again, for fear of arrest and conviction. Aside from the obvious harms associated with imprisonment (see briefing no. 3), the consequences of obtaining a criminal record are considerable and can affect access to future employment, education and even social services such as housing. Criminal status also exposes people who use drugs to police abuse including beatings, extortion and even torture.

Drug paraphernalia laws

In many countries, carrying drug paraphernalia such as needles and syringes, crack pipes and foil for smoking heroin is illegal. This can deter safer drug use as users fear attracting police attention. It can also deter the initiation of harm reduction services as service providers worry about the legal implications of providing clean equipment.

'Incitement', 'encouragement' or 'aiding and abetting' laws

Laws that create criminal penalties for incitement to use drugs or facilitating/encouraging drug use exist in many countries. Such laws are not often based on the reality of drug use and initiation (which is often between peers, siblings and friends who are also using) and can act as a deterrent to harm reduction services. Harm reduction providers are frequently accused of facilitating drug use.[3]

Arbitrary age restrictions on harm reduction services

Injecting drug users who are under 18 (and sometimes older, e.g. in Sweden) are often denied access to lifesaving harm reduction services. In many countries this ignores the fact that children as young as 10 or 12 are known to inject drugs.[4]

Drug user registries

Once they come to the attention of health services, drug users in many countries are added to 'registries' where their status as a drug user may be made known to others. Drug user registration serves as a form of state control over people who are dependent on drugs and imposes restrictions on their rights. The process brands people as drug users for years, sometimes indefinitely, regardless of whether they have ceased using drugs.[5] In China, for example, methadone treatment patients are added to government registries linked to their identification documents and accessible to the police. In Thailand, once registered, drug users remain under surveillance by police and anti-drug agencies, and information about patient drug use is shared. Fear of registry discourages individuals from accessing care, even though it is free.[6] In Russia, people who enroll in public drug treatment programs are added to registries (those who can afford to seek private drug treatment are not). Being listed on the registry can lead to loss of employment, housing and even child custody. Faced with these consequences, many people don't see public drug treatment as a viable option.[7]

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Policing practices

Appropriate, human rights compliant policing is essential for effective drug policies and positive health outcomes for drug users. Unfortunately, in country after country, the experience is often the opposite, partly due to the poor laws being enforced and partly due to policing practices. In many places, police target drug users and harm reduction services, seeing easy opportunities to harass, entrap and extort clients.

Police presence at or near harm reduction programs drives people away from these services due to fear of arrest or other punishment.[8] In Ukraine, for example, drug users have reported being arrested multiple times at legal needle exchange sites. Individuals have been severely beaten for possessing syringes at or near needle exchange points.[9]

In Georgia, drug crackdowns in 2007 resulted in four percent of the country's male population being tested for drugs, many under forced conditions. Thirty-five percent of these went on to be imprisoned on a drug-related charge.[10] In Thailand, the 2003 'war on drugs' that resulted in more than 2,800 extrajudicial killings has had a lasting impact on drug users' access to fundamental health care services. Studies reported a significant decline in the number of people seeking treatment for drug use during the 'war on drugs', and also reported that a significant percentage of people who had formerly attended drug treatment centers went into hiding.[11] Years later, many people who use drugs still refrained from seeking treatment at public hospitals for fear that their drug use (past or current) will be shared with police. This fear is not unfounded. Public hospitals and drug treatment centers collect and share information about individuals' drug use with law enforcement, both as a matter of policy and in practice.[12]

Amnesty International has documented a reported rise in complaints of extrajudicial executions during Mexico's ramped up counter-narcotics operations.[13]

Disproportionate drug penalties and discriminatory application of drug control measures

The penalties for possession for personal use, or with intent to supply in many countries are severe, from lengthy prison sentences to the death penalty. In the United States, three strikes legislation in some states can result in life sentences for petty and non-violent drug crimes.[14] In many countries, people are sentenced to death and executed for drug offenses, sometimes for possession of relatively small amounts of illicit drugs.[15] In some countries, such sentences are mandatory. Mandatory death sentences that do not take mitigating considerations into account have been condemned as a violation of international law by the Commission on Human Rights,[16] the Human Rights Committee,[17] the Inter-American Court of Human Rights[18] and the Special Rapporteur on extrajudicial, summary or arbitrary executions, as well as some national courts. Such penalties are entirely disproportionate to the crimes involved and have been shown to be ineffective in reducing drug consumption and drug-related crime.[19]

The impact of drug control is often disproportionately focused on vulnerable groups and marginalized communities: peasant farmers, small time dealers, low level drug offenders, and racial and ethnic minorities or indigenous peoples. In the United States, African-American men and women are sent to prison for drug charges at rates many times that of their white counterparts and the application of mandatory minimum sentencing often subjects them to equal or harsher penalties than the principals of the drug trade.[20] In Brazil, the vast majority of those killed by police in their ongoing war against drugs have been poor, black, young boys from favela communities, for whom involvement in the drug gangs is one of the few viable opportunities for employment.[21]

Drugs and fair trial standards

Fair trial standards for drug offenders are not met in many contexts. For example, in Iran many drug smuggling cases are handled by Revolutionary Courts. The UN Working Group on Arbitrary Detention has called for the abolition of such courts because of the failure to provide adequate due process.[22] One report estimated that 99 percent of the cases handled by the revolutionary courts involve drugs.[23] In Indonesia and Saudi Arabia, the Special Rapporteur on extrajudicial, summary or arbitrary executions, raised concerns about statements made under torture that contributed to the suspect being convicted and sentenced to death.[24] The Special Rapporteur on Torture uncovered similar cases, many relating to drug offenses, in his 2008 mission to Indonesia.[25]

Drugs and detention without trial

Some countries detain drug suspects without trial and with very few due process safeguards. In Malaysia, for example, provisions of the Dangerous Drugs Act give the authorities the power to detain drug trafficking suspects without a warrant for between up to 60[26] days without a court appearance. After such period, the Home Ministry can issue a detention order, which entitles the detainee an appearance before a court to argue for release.[27] However, should the court deny release to the suspect, the person can be held for successive two-year intervals.[28] An advisory board reviews the suspect's detention but such a procedure falls far short of the procedural rights of a court proceeding.[29] It has been alleged that police detain people under this act after having been acquitted by the courts.[30] In 2007, 798 people were detained under this act and another 805 in the first eight months of 2008.[31]

Coerced and compulsory drug dependence treatment (See briefing no. 4)

In some countries, people who have broken drug laws may be coerced or even compelled to spend years in drug treatment centers, regardless of whether they need treatment, and without due process of law. A 2004 survey found that nine percent of 3,213 Chinese heroin users had taken extreme steps such as swallowing glass to gain a medical exemption from forced treatment.[32]

Criminal laws, law enforcement and HIV/AIDS

UN health and drug control agencies—including UNAIDS, WHO, UNODC and INCB—have endorsed and promoted a wide range of interventions for the prevention, treatment, and care of HIV among people who use drugs, including opioid substitution therapy and ensuring access to and use of needle and syringe exchange programs, as essential components of HIV/AIDS programs for people who use drugs. Yet punitive laws, policies and practices keep many drug users from receiving these lifesaving services, even in countries where they are legal.

Research in several countries has established that criminal laws proscribing syringe possession and associated policing practices targeting people who use drugs increase the risk of HIV in both direct and indirect ways.[33] This reality is reflected in the International Guidelines on HIV and Human Rights, which state that:

> *States should review and reform criminal laws and correctional systems to ensure that they are consistent with international human rights obligations and are not misused in the context of HIV or targeted against vulnerable groups.*
> *...*
> *Criminal law should not be an impediment to measures taken by States to reduce the risk of HIV transmission among injecting drug users and to provide HIV-related care and treatment for injecting drug users.*[34]

HIV treatment is also affected by a legal and policy environment that criminalizes and stigmatizes a population at elevated risk. In many countries where people who use drugs represent a significant, or even a majority, of those living with HIV, their access to treatment is disproportionately low relative to other people living with HIV. In China, figures from 2006 showed that while 48 percent of HIV cases were people who inject drugs, this group represented only one percent of those accessing ART. In Malaysia, 75 percent of HIV cases were among people who inject drugs, while only five percent of injectors had access to ART.[35] A similar discrepancy was found in a WHO Europe study of European countries, particularly in Eastern Europe.[36]

Drug law and policy reform and the human rights of people who use drugs

Concerns about the harmful effects of a criminal justice approach on the health and human rights of people who use drugs have prompted a number of governments to decriminalize possession of small quantities of drugs for personal use either in law or in practice. Spain, Portugal and Italy, for example, do not consider possession of drugs for personal use a punishable offense. In the Netherlands and Germany, possession for personal use is illegal, but guidelines are established for police and prosecutors to avoid imposing punishment.[37] Many Latin American countries (including Brazil, Mexico and Argentina) have decriminalized possession for personal use, either by court decree or through legislative action, moves supported by high profile politicians including ex-presidents.[38] Portugal has decriminalized all possession for personal use.[39]

In the United States, some jurisdictions have protected drug users' access to harm reduction services through court orders barring police from arresting needle exchange participants for drug possession based on residue in used syringes, or through police department orders directing police not to patrol areas near syringe exchange sites.[40] At least 27 cities worldwide, including in Switzerland, Germany, Australia and Canada have established supervised injection sites that permit drug users to inject in a safe, hygienic environment without risk of arrest or prosecution for onsite possession of illegal drugs.[41] At least 10 countries in Europe and Central Asia have prison-based needle exchange programs, including Iran, Moldova and Kyrgyzstan.[42]

The UN drug conventions grant some flexibility with respect to penalization of possession and use of controlled substances.[43] According to the International Narcotics Control Board, the treaty body charged with monitoring the drug control treaties and interpreting their provisions, "[t]he international drug control treaties do **grant some latitude with regard to the penalization of personal consumption-related offenses**. Parties to the 1961 Convention are under an obligation not to permit the possession of drugs for personal non-medical consumption. Parties to the 1988 Convention are required to establish as criminal offenses activities preparatory to personal consumption, **subject to each party's constitutional principles and the basic concepts of its legal system**."[44] The INCB has, for example, concluded that Portugal's 2001 drug law reform decriminalizing the possession of small amounts of controlled drugs for personal use and drug use itself was consistent with the international drug control treaties.[45] UNODC has also raised concern about the harmful consequences of drug criminalization on the health and human rights of people who use drugs, and has encouraged the use of creative approaches to drug enforcement, including stopping the incarceration of petty offenders, and reforming performance indicators that promote high numbers of arrests (as compared to targeting violent criminals or high volume dealers).[46]

Numerous reviews—including that done by the UNDCP Legal Affairs Section at the request of the INCB—have similarly concluded that the implementation of such harm reduction measures as opioid substitution treatment, sterile syringe programs, supervised consumption facilities and heroin prescription programs are consistent with, and not in violation of, state obligations under the three UN Drug Control Conventions.[47]

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Briefing 3

Human Rights and Drug Policy

Harm Reduction in Places of Detention

"The development of prison policy, legislation, and programmes which are in conformity with international human rights norms should be based upon empirical evidence of their effectiveness at reducing the risks of HIV transmission, an assessment of the harms and costs of HIV/AIDS and related risk behaviours in prisons, and the health of both the prison population and the public at large."

—UNODC, WHO & UNAIDS, 2006[1]

Context: Injecting drug use, HIV/AIDS and places of detention

Over nine million people are incarcerated in penal institutions worldwide.[2] As this figure represents only the prison population at any moment in time, it significantly underestimates the total number of persons who pass through prisons each year, often for short periods of detention. More than a third of those incarcerated in jails and prisons around the world—nearly 10 million people each year—are pretrial detainees.[3]

According to the WHO, prisons are places where, "Two of the greatest public health problems facing all societies overlap: the epidemic of HIV/AIDS and the pandemic harmful use of psychotropic substances such as alcohol and illegal drugs."[4] In many countries, this intersection fuels very high rates of blood-borne diseases, such as HIV and hepatitis C, among prisoners who share syringes to inject drugs. Often, the groups most vulnerable to HIV/AIDS are also often those at increased risk for incarceration as a result of socioeconomic conditions. As a result, rates of HIV and hepatitis C infection are significantly higher among prison populations than in the community outside of prisons.[5] This is often exacerbated in places of detention by high rates of tuberculosis, sexually transmitted infections, drug use and poor mental health.

HIV infection can spread with alarming speed in prisons, particularly among prisoners who inject drugs. For example, in 2002 an HIV outbreak among injecting drug using prisoners was identified at the Alythus Prison in Lithuania, during which time 263 prisoners tested positive for HIV within the space of a few months. Before this outbreak, testing had identified only 18 HIV infections in Lithuania's entire prison system, and only 300 persons were known to be living with HIV in the country as a whole.[6] This example illustrates the implications of inadequate prison health systems on overall public health, and national levels of disease and ill-health.

High rates of HIV and other infectious diseases in prisons can lead to alarmingly high rates of mortality among prisoners. In South African prisons, where high rates of both HIV and TB infection are evident, officials recorded a 584% increase in 'natural deaths' of prisoners between 1995 and 2000. When the Department of Correctional Services examined post-mortem reports on these deaths in 1999, it concluded that 90%were HIV-related.[7] Based upon these figures and the continuing growth of the South African prison population, the study predicted that, by 2010, 45,000 people would die in the country's prisons.[8]

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The vast majority of people in prison or detention are eventually released back into the outside community. Reducing the spread of HIV in prisons is therefore integrally linked to reducing the spread of infection in the society as a whole.

Harm Reduction in Places of Detention Worldwide

Despite the alarming levels of HIV infection in many prisons around the world, the evidence of high-risk behaviors among persons in detention and the documented cases of HIV transmission and outbreaks of infection among incarcerated populations, few countries have implemented the health measures necessary to prevent the spread of HIV among this vulnerable group.

According to the WHO, UNODC and UNAIDS,[9] a comprehensive set of interventions in prisons should include:

- information and education, particularly through peers
- provision of condoms and other measures to reduce sexual transmission
- needle and syringe programs
- drug dependence treatment, in particular opioid substitution therapy
- voluntary counseling and HIV testing
- HIV care, treatment and support, including provision of antiretroviral treatment

A small number of countries have been innovative in implementing HIV prevention and treatment services for prisoners. For example, 10 countries currently allow needle/syringe programs in at least some prisons, and 37 allow opioid substitution therapy. However, the vast majority still fall far short of a comprehensive standard. Even in countries where harm reduction measures are allowed, many of these programs are small in scale, are available only in selected regions or prisons and/or do not include all the elements necessary for a comprehensive response.[10]

This failure to provide harm reduction services in prisons is often due to lack of political will or to policies that prioritize zero tolerance for drug use over evidence-based harm-reduction initiatives. In some cases, it is the result of a lack of state resources and technology to meet the overwhelming need. In some cases it is both of these.

Negative public attitudes towards people in detention act as a barrier to objective and pragmatic discussions of prison health policy. In the case of drug use and health, this is further impeded by the unwillingness of many governments to openly address this issue, as even admitting that drug use is occurring in the secure environment of custody is seen as an admission of security failure. At the same time, prisoners report sharing a single needle with dozens of other prisoners. There is also an assumption that harm reduction programs within the prison context will create risks to the safety of prisoners and staff, despite the fact that the experience in countries that have implemented these programs in prisons is that they can be provided in a safe and secure manner.[11]

The unwillingness to address these health concerns in an open and evidence-based fashion further jeopardizes the health and human rights of an already vulnerable population.

Harm Reduction and the right to health of persons in detention

The failure of states to implement comprehensive harm reduction measures in places of detention—including needle/syringe programs and opioid substitution therapy—violates their obligations in international human rights law.

All persons deprived of liberty have the right to the highest attainable standard of health. The right to health of persons in detention is articulated not just within economic, social and cultural rights, but also finds expression within civil and political rights mechanisms. The Human Rights Committee, for example, has stated that questions of health in detention could be raised under the right to life (Article 6) or the right to humane treatment (Article 10).[12] Indeed both the right to life[13] and right to humane treatment[14] impose positive obligations upon states parties to protect the lives and/or well-being of persons in custody. This has often been interpreted to require government authorities to take action to safeguard the health of prisoners.

The Committee on Economic, Social and Cultural Rights has stated explicitly that, "States are under the obligation to respect the right to health by, inter alia, refraining from denying or limiting equal access for all persons, including prisoners or detainees…[to] curative and palliative health services."[15] It has also taken the opinion that states have the obligation to implement preventative health programmes in places of detention. In its 1997 Concluding Observations on the Russian Federation, the Committee expressed specific concern "over the re-emergence of tuberculosis… particularly in prisons, where the health and social conditions of detention are unacceptable."[16] This concern was repeated in the Committee's 2003 Concluding Observations.[17] In both cases, the Committee recommended that the states take steps to combat the spread of TB in prisons, which indicates an obligation under the ICESCR to implement preventative health programs in prisons.[18]

The Committee has found that lack of provision of harm reduction measures conflicts with state obligations under Article 12 of the Covenant. In its 2006 Concluding Observations on Tajikistan, the Committee expressed concern at "the rapid spread of HIV in the State party, in particular among drug users, prisoners, [and] sex workers," and specifically called upon the government to "establish time-bound targets for extending the provision of free…harm reduction services to all parts of the country."[19] In its 2007 Concluding Observations on Ukraine, the Committee recommended that the state "continue its efforts and take urgent measures to improve the accessibility and availability of HIV prevention to all the population and the treatment, care and support of persons living with HIV/AIDS, including in prisons and detention centres," including making "drug substitution therapy and other HIV prevention services more accessible for drug users."[20]

Harm reduction in places of detention and freedom from cruel, inhuman and degrading treatment

The Special Rapporteur on Torture and Other Cruel, Inhuman or Degrading Treatment and Punishment has recently recommended that, "Needle and syringe programmes in detention should be used to reduce the risk of infection with HIV/AIDS."[21] He also noted that, "[W]ithdrawal symptoms can cause severe pain and suffering if not alleviated by appropriate medical treatment" [22] and that "denial of medical treatment and/or absence of access to medical care in custodial situations may constitute cruel, inhuman or degrading treatment or punishment and is therefore prohibited under international human rights law."[23]

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12 Cabal and Pasini v Australia (7 August 2003) UN Doc CCPR/C/78/D/1020/2002, para 7(7).
13 Human Rights Committee, "General Comment No. 6: The Right to Life Article 6" (30 April 1982) UN Doc HRI\GEN\1\Rev.1 para 5.
14 Human Rights Committee "General Comment 21: Humane treatment of persons deprived of liberty (Art. 10)" (10 April 1992) Compilation of General Comments and General Recommendations Adopted by Human Rights Treaty Bodies UN Doc.HRI/GEN/1/Rev.6 para 3.
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18 Committee on Economic, Social and Cultural Rights (n 16) para 61; Committee on Economic, Social and Cultural Rights (n 17) para 47.
19 UN Committee on Economic, Social and Cultural Rights "Concluding Observations: Tajikistan," 24 November 2006, UN Doc. No. E/C.12/TJK/CO/1 para 70.
20 UN Committee on Economic, Social and Cultural Rights "Concluding Observations: Ukraine," 4 January 2008, UN Doc. No. E/C.12/UKR/CO/5 para 51.
21 UN Human Rights Council, Report of the Special Rapporteur on Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, Manfred Nowak, 14 January 2009, A/HRC/10/44, para. 74
22 UN Human Rights Council, Report of the Special Rapporteur on Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, Manfred Nowak, 14 January 2009, A/HRC/10/44, para. 57.
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Briefing 4

Human Rights and Drug Policy

Compulsory Drug Treatment

"Informed consent, as an integral part of the right to health, must be guaranteed with every protection against stigmatization or discrimination on any grounds…"

—Anand Grover[1]

UN Special Rapporteur on the right to the highest attainable standard of health

"With respect to drug treatment, in line with the right to informed consent to medical treatment (and its "logical corollary", the right to refuse treatment), drug dependence treatment should not be forced on patients."

—Antonio Maria Costa

Executive Director, UN Office on Drugs and Crime[2]

Context: drug dependence and compulsory drug treatment

The World Health Organization (WHO) describes drug dependence as the strong desire to consume psychoactive substances, difficulty controlling substance use, the continued use of psychoactive substances despite physical, mental and social problems associated with that use, increased tolerance over time, and sometimes withdrawal symptoms if the substance is abruptly unavailable.[3] Research has shown that drug dependence is not a failure of will or of strength of character, but a chronic, relapsing medical condition with a physiological and genetic basis.[4]

In many countries, people identified as drug users are consigned for extended periods of time to locked "treatment" facilities for months, or even years. This may occur without trial or any semblance of due process. Often run by military or public security forces and staffed by people with no medical training, these centers rarely provide treatment based on scientific evidence.

Compulsory drug treatment in policy and practice: reports from the field

In states that enforce policies of compulsory drug treatment for drug users wide scale incidents of arbitrary arrest and detention with no due process protections are frequently reported. Facilities where detainees are held often fail to meet basic medical and human rights standards.

In Cambodia, people who use drugs – dependent or not - are routinely rounded up by police and sent to government-run drug detention centers, where arduous physical exercises and forced labor are the mainstays of their "treatment". In these centers, they face torture and extreme physical cruelty – including sexual violence, and being shocked with electric batons and beaten with twisted electrical wire. People are detained in such centers regardless of entry assessments that they are not dependent on drugs. There is no access to legal counsel while in police custody or during subsequent detention in the centers, no judicial authorization of detention, nor any opportunity for its review. In 2008, nearly one-quarter of detainees in Cambodia's compulsory drug detention centers were aged 18 or below. They were detained alongside adults, forced to work, and physically abused.[5]

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Abusive conditions are prevalent in many of China's compulsory drug detention centers, notwithstanding its 2008 Anti-Drug Law that referred to drug users as "patients" and promised legal protections for them. In fact, China's 2008 Anti-Drug Law gives government officials and security forces widespread discretion to incarcerate individuals suspected of drug use for up to six years –without trial or judicial oversight. Individuals detained in Chinese drug detention centers are routinely beaten, denied medical treatment, and forced to work up to 18 hours a day without pay. Although sentenced to "rehabilitation," they are denied access to effective drug dependency treatment and provided no opportunity to learn skills to reintegrate into the community.[6] According to UNAIDS, half a million people are confined in drug detention centers at any given time.

In Vietnam, there are 109 detention centers for drug treatment (also known as "06 centers") detaining up to 60,000 people who use drugs. Terms of detention are as long as five years: two of "treatment" and three of labor in facilities built near the detention centers. Detainees have no access to lawyers, no trial and no means of challenging their detention. Detainees are frequently denied evidence-based treatment for drug dependence, including during acute withdrawal from drug use. They are sometimes forced to work long hours for below-market wages, with deductions for food and lodging taken from their wages. Those who fail to meet work quotas are isolated and punished.

Since 2003, thousands of people in Thailand have been coerced into "drug treatment" centers run by security forces. Before "treatment" even begins, people are held for "assessment" for extended periods in prison. In the centers, military drills on the orders of security personnel are a mainstay of so-called "treatment." Thailand's coerced treatment and rehabilitation policy has had long-term consequences on the health and human rights of drug users, as many continue to avoid drug treatment or any government-sponsored health services out of fear of arrest or police action.[7]

People who use drugs in some facilities in Russia have been subjected to "flogging therapy," handcuffed to beds during detoxification and denied medication to alleviate painful withdrawal symptoms. Those who enter treatment voluntarily in Russia are consigned to locked wards, in some cases with fatal consequences.[8] In 2006, 46 young women died in a fire in a Moscow substance abuse hospital, where staff had abandoned residents to struggle against locked windows and doors.[9]

In Singapore, according to a government report distributed in March 2009, people who use drugs can be arbitrarily detained for extended periods of time and caned if they relapse, even though relapse is a common milepost on the road to recovery.[10]

In Laos, people who use drugs are arbitrarily detained in boot camp-like centers, where they receive neither evidence-based drug treatment nor appropriate medical care. Detainees – among them hundreds of children, many housed alongside adults -- are subjected to routine physical and sexual abuse.[11]

Human rights principles and compulsory drug treatment

Drug dependence treatment is a form of medical care, and therefore must comply with the same standards as other forms of health care. In developing and implementing effective drug dependence treatment programs, human rights must be respected and protected. These rights include the right of people who use drugs to enjoy the highest attainable standard of physical and mental health; patient rights, including confidentiality and the right to receive information regarding one's state of health; the human rights principle of informed consent (including the ability to withdraw from

treatment); and the right to non-discrimination in health care and to be free from torture or other cruel, inhuman or degrading treatment.

Medically inappropriate treatment

States that are parties to the *International Covenant on Economic, Social and Cultural Rights (ICESCR)* have recognized the right of every person to enjoy "the highest attainable standard of physical and mental health" (Article 12). The Committee on Economic, Social and Cultural Rights (CESCR) has stated that a state's health facilities, goods and services should be available, acceptable, accessible and of good quality.[12] Forms of supposed "treatment" and "rehabilitation" such as detention, forced labor, forced physical exercises and military drills do not meet the requirement under international law that drug dependence treatment be culturally and ethically acceptable, scientifically and medically appropriate, and of good quality.

Elements of supposed "treatment" and "rehabilitation" may also constitute torture or cruel, inhuman or degrading treatment or punishment. The Convention Against Torture establishes a clear legal obligation on state parties to investigate credible allegations of torture and cruel and inhuman treatment or punishment and to hold perpetrators accountable.

Compulsory treatment as a matter of course and 'en masse'

International human rights standards require that medical treatment be based on free and informed consent, which includes the right to refuse medical treatment. The right to informed consent to treatment is integral to the rights to health, to privacy and bodily integrity, and freedom from torture and cruel, inhuman and degrading treatment or punishment.

According to the CESCR, "The right to health contains both freedoms and entitlements. The freedoms include the right to control one's health and body… and the right to be free from interference, such as the right to be free from torture, nonconsensual medical treatment and experimentation… obligations to respect [the right to health] include a State's obligation to refrain (…) from applying coercive medical treatments, unless on an exceptional basis for the treatment of mental illness or the prevention and control of communicable diseases. Such exceptional cases should be subject to specific and restrictive conditions, respecting best practices and applicable international standards, including the Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care."[13]

The presumption that people who use drugs lack capacity to consent to treatment is dangerous because it ignores relevant legal safeguards regarding competence to make treatment decisions, and widens the scope of potential abuse.

UN agencies (including UNAIDS, WHO, UNICEF and UNDP), and the Global Fund for AIDS, Tuberculosis and Malaria have acknowledged reports of illegal detention and human rights abuses (including torture) in several countries. They have called for the closure of compulsory drug detention centers and their replacement with community and evidence-based, voluntary drug treatment that respects human rights standards.[14]

The UN Office on Drugs and Crime has also recognized that where systems of supposed drug "treatment" and "rehabilitation" force people into treatment as a matter of course and en masse, such systems violate international human rights standards. According to UNODC, "With respect to drug treatment, in line with the right to informed consent to medical treatment (and its "logical corollary", the right to refuse treatment), drug dependence treatment

should not be forced on patients. Only in exceptional crisis situations of high risk to self or others can compulsory treatment be mandated for specific conditions and for short periods that are no longer than strictly clinically necessary. Such treatment must be specified by law and subject to judicial review. . . . Under no circumstances should anyone subject to compulsory treatment be given experimental forms of treatment, or punitive interventions under the guise of drug-dependence treatment."[15]

Many systems force people to undergo supposed "treatment" and "rehabilitation" regardless of whether there is an actual lack of capacity on the part of the person to consent to treatment, a threat to themselves or others, or, indeed, a need for treatment established by a trained health care professional. Often people are forced to undergo treatment not because they need it, but because they broke the law relating to drug use and/or possession. When such a system ignores an individual's treatment needs (if any), it cannot be justified by a demonstrable benefit from the proposed intervention. Such a system will often deny an individual the opportunity to cease or modify his or her treatment plan or to review the ongoing necessity of treatment. Such systems also fail to provide procedural guarantees that the compulsory intervention will not be provided for longer than strictly necessary. Each individual should be clinically assessed based on their treatment needs and compulsory treatment should only be allowed when an individual lacks the capacity to consent to treatment and procedural safeguards have been ensured.

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Briefing 5

Human Rights and Drug Policy

Controlled Essential Medicines

"Numerous studies have identified common problems that impede availability and accessibility of controlled medicines for the treatment of pain. Many countries do not recognize palliative care and pain treatment as priorities in health care, have no relevant policies, have never assessed the need for pain treatment or examined whether that need is met, and have not examined the obstacles to such treatment...The failure to ensure access to controlled medicines for the relief of pain and suffering threatens fundamental rights to health and to protection against cruel, inhuman and degrading treatment."

–Anand Grover and Manfred Nowak, UN Special Rapporteurs on health and torture[1]

"Although the World Health Organization (WHO) considers access to controlled medicines, including morphine and codeine, to be a human right, it is virtually non-existent in over 150 countries."

–Professor Sevil Atasoy, President of the International Narcotics Control Board[2]

Access to controlled essential medicines: the treatment gap

Several drugs on the WHO's Model List of Essential Medicines, including morphine, methadone and buprenorphine, are also controlled substances under the international drug control conventions.[3] These medications are essential in the treatment of moderate to severe pain and opioid drug dependence. Lack of medical access to these essential medicines is a global problem. The WHO estimates that:

- Each year, tens of millions of people suffer untreated moderate to severe pain, including 1 million HIV/AIDS patients and 5.5 million terminal cancer patients.
- If opioid substitution therapy was made readily available globally, it could prevent up to 130,000 new HIV infections annually, reduce the spread of hepatitis C and other blood-borne diseases, and decrease deaths from opioid overdose by 90 percent.[4]

Barriers to access

Medicines controlled under the international drug conventions are subject to stricter regulation than other medicines: government authorization is necessary to import, manufacture or distribute controlled medicines, they may only be dispensed upon prescription, and doctors and pharmacies often require special licenses or permission to prescribe and dispense them.[5] These regulations aim to prevent the diversion of controlled medicines for illicit use.

While these regulations pursue a legitimate goal, governments must make sure they do not unnecessarily impede medical access. The aim of preventing misuse must be balanced against the obligation to ensure access to essential medications.[6] In many countries throughout the world, that balance has not been reached. Unnecessarily strict and complex regulation is recognized as a major barrier to access to controlled medications.[7]

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Several other barriers to access to controlled essential medicines add to, and are often related to, the problem of unnecessarily strict or complex regulation. Many doctors have unfounded fears that prescribing controlled essential medicines will lead to addiction, because they have not received education regarding the WHO's recommendations on prescribing opioids for pain management and substitution therapy.[8] Doctors who are insufficiently educated regarding pain management and their country's regulation of controlled drugs are often deterred from prescribing because they fear losing their medical license, or even prosecution, if they make an error handling these medicines.[9] Many governments have no policies to promote access to pain management, palliative care, or opioid substitution therapy, and have poor supply and distribution systems for controlled medicines.[10] Although morphine and methadone are available very cheaply on the international market, complex regulation and poor distribution systems can increase their price dramatically, making cost a barrier for many patients.[11] For example, in some countries more expensive opioid formulations, such as prolonged-release morphine tablets and transdermal fentanyl patches are available, but the cheaper formulations, including basic oral morphine in tablet or powder form, are not. In some cases pharmaceutical companies withdraw basic oral morphine from the market to promote the sale of more expensive formulations. In other countries, the cheapest oral morphine formulations do not have regulatory approval.[12]

In many low- and middle-income countries with injection-driven epidemics, government policies mandate criteria for access to, or maintenance of, treatment for drug users which can become barriers to treatment. Human Rights Watch, the International Harm Reduction Association, the Open Society Institute and others have documented instances where criteria regulating access to drug treatment, effectively operate as barriers in the countries where they are enforced. For example, this has occurred with laws that require drug users to undergo multiple physiological tests or to be reviewed by panels of physicians prior to admission into drug treatment. This condition can mean that drug users must choose between continued use of illicit drugs or face unmedicated withdrawal, yet the tests and reviews could also be conducted after admission when users have access to treatment while undergoing the tests. Similarly, requirements that prospective patients show multiple documented experiences of drug-free treatment before they can be admitted into maintenance treatment programs, even where drug-free treatment is unaffordable or unavailable; that impose regulatory restrictions on adjustments of the dose of opioid medications patients receive, rather than leave that decision to medical doctors; and that impose automatic expulsion from treatment programs for the use of illicit drugs while in treatment, when drug dependency – recognized as a chronic relapsing medical condition - is the health condition being treated, can all create unnecessary barriers. Countries should regularly review entry criteria to ensure they do not unnecessarily impede access to drug dependence treatment.[13]

Access to controlled essential medicines and the right to the highest attainable standard of health

In 2009, Human Rights Watch documented the poor availability of pain treatment and palliative care in India.[14] Its report, "Unbearable Pain: India's Obligation to Ensure Palliative Care," found that hundreds of thousands of patients with advanced cancer suffer from severe pain without access to morphine or other strong pain relievers. People who had suffered from pain without treatment routinely told Human Rights Watch that their suffering was so severe that they preferred to die rather than live with the pain. The organization attributed this situation to inadequate policy-making by the government, a lack of instruction on palliative care for health care workers, and unnecessarily restrictive drug regulations in more than half of India's states.

Many other countries around the world face problems to those of India because governments have not taken adequate steps to ensure that palliative care is integrated into national cancer and HIV strategies, that doctors and nurses are trained, and that drug regulations do not unnecessarily impede the availability of pain medications like morphine. As a result, millions worldwide suffer unnecessarily from excruciating pain.

At its 12th session in 2009, the **Human Rights Council** adopted a resolution that recognized "access to medicine is a fundamental element in achieving progressively the full realization of the right of everyone to the enjoyment of the highest attainable standard

of physical and mental health."[15] The same resolution stressed "the responsibility of States to ensure access to all, without discrimination, of medicines, in particular essential medicines, that are affordable and of good quality."

The protection from discrimination includes people living with HIV/AIDS[16] and people who use drugs.[17]

In 2005, the **Economic and Social Council (ECOSOC)** passed a resolution on "treatment of pain using opioid analgesics" in which it "recognizes the importance of improving the treatment of pain, including by the use of opioid analgesics…and calls upon Member States to remove barriers to the medical use of such analgesics."[18]

In its General Comment on the right to the highest attainable standard of health, the **Committee on Economic, Social and Cultural Rights** emphasized that the provision of essential drugs, as defined by the WHO, is a core obligation of the right to health. The Committee also emphasized that need for "attention and care for chronically and terminally ill persons, sparing them avoidable pain and enabling them to die with dignity."[19]

In its Concluding Observations on Ukraine's report under the Covenant, in 2008, the Committee stated that is was "gravely concerned at the high prevalence of HIV/AIDS...and the limited access by users to substitution therapy."[20] Injecting drug users who give birth in Russia and Ukraine report that maternity wards frequently offer no substitution treatment, requiring mothers who are receiving methadone or buprenorphine, or those who are active drug users, to leave the hospital prematurely to avoid painful withdrawal symptoms.[21]

In a letter to the Chairperson of the 52nd Commission on Narcotic Drugs, Anand Grover, **Special Rapporteur on the right to the highest attainable standard of health**, and Manfred Nowak, **Special Rapporteur on torture and other cruel, inhuman and degrading treatment or punishment**, wrote that "*human rights law requires that governments must provide essential medicines – which include, among others, opioid analgesics – as part of their minimum core obligations under the right to health.*"[22]

Freedom from cruel, inhuman or degrading treatment

In a January 2009 report to the Human Rights Council, Manfred Nowak, **Special Rapporteur on torture and other cruel, inhuman and degrading treatment or punishment**, stated:

"from a human rights perspective, drug dependence should be treated like any other health-care condition...denial of medical treatment and/or absence of access to medical care in custodial situations may constitute cruel, inhuman or degrading treatment or punishment and is therefore prohibited under international human rights law...States have a positive obligation to ensure the same access to prevention and treatment in places of detention as outside."

The Special Rapporteur also said:

"Given that lack of access to pain treatment and opioid analgesics for patients in need might amount to cruel, inhuman and degrading treatment, all measures should be taken to ensure full access and to overcome current regulatory, educational and attitudinal obstacles to ensure full access to palliative care."[23]

Right to seek, receive and impart information

The right to seek receive and impart information is an important underlying determinant of health. Ensuring accurate information is available can mean many things in different contexts. In some instances it could simply mean making sure some medicines are accurately reflected in official literature while in the case of India, it would likely mean improving palliative care education in medical schools.

States should work to remove barriers related to information about available medicine in order to comply with civil and political rights obligations[24] as well as those related to economic, social and cultural rights. Information should be available and accessible to people in order for them to make informed choices regarding their care. The Committee on Economic, Social and Cultural Rights has made clear that "states should refrain from … censoring, withholding or intentionally misrepresenting health-related information."[25]

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8 Human Rights Watch, *"Please, Do Not Make Us Suffer Any More…"*, 25-26.
9 Ibid, pp. 33-35.
10 Ibid, pp. 18-25. Palliative care seeks to improve the quality of life of patients with life-limiting illness, by assessing and treating pain and other physical symptoms and providing psychosocial and spiritual care to the patient and their family: see WHO, "WHO Definition of Palliative Care," http://www.who.int/cancer/palliative/definition/en/, (accessed October 23, 2009).
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22 Letter from Manfred Nowak and Anand Grover to Special Rapporteur to Her Excellency Ms Selma Ashipala-Musavyi, p. 4.
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Briefing 6

Human Rights and Drug Policy

Crop Eradication

We are farther than ever from the announced goal of eradicating drugs.

Latin American Commission on Drugs and Democracy, 2009

The hundreds of millions of dollars we spend on crop eradication has not had any damage on the Taliban…On the contrary, it has helped them recruit. This is the least effective program ever

Richard Holbrook, US Special Envoy to Afghanistan, 2009

Historically, the main focus of international drug control efforts has been on supply side measures aimed at reducing the supply, and therefore availability, of drugs on the streets in consumer countries. This has long been criticized as developed nations imposing their problems on poorer developing countries. Supply reduction has taken the form of counter-narcotics law enforcement as well as forced crop eradication programs, particularly in Latin America, the so-called Golden Triangle in East Asia, and the Golden Crescent in the Middle East. Only in recent years have measures aimed at reducing demand come more to the fore.

Most states in the world have now ratified the relevant international conventions requiring the eradication of certain plants such as cannabis, opium poppy and coca. For example, article 14, paragraph 2 of the 1988 United Nations Convention Against Illicit Traffic in Narcotic Drugs and Psychotropic Substances states: "Each Party shall take appropriate measures to prevent illicit cultivation of and to eradicate plants containing narcotic or psychotropic substances, such as opium poppy, coca bush and cannabis plants, cultivated illicitly in its territory." Article 14, paragraph 2 also states: "The measures adopted shall respect fundamental human rights and shall take due account of traditional licit uses…as well as the protection of the environment." In practice, however, human rights, traditional uses, and the environment have not been given due consideration in crop eradication campaigns.

Crop Eradication Measures

Aerial Spraying

The only country where aerial fumigation currently takes place is Colombia. The consequences have been disastrous, damaging health, food crops and the environment, and contributing to the massive internal human displacement in the country. There are now more than four million internally displaced people (IDPs) in Colombia, most of them displaced due to drug fueled civil conflict and many others as a direct result of anti-narcotic efforts, including aerial fumigation campaigns targeting coca. However, as people displaced by fumigation or other counter-narcotics efforts are not, under domestic law, considered displaced, the government of Colombia considers there to be closer to three million IDPs. The true number displaced by counter-narcotic efforts is extremely difficult to ascertain, due in no small part to the fact that those so displaced are not entitled to social welfare, and so often do not inform the authorities of the true reason.

Health complaints associated with aerial spraying with glyphosate (or "Roundup") include respiratory problems, skin rashes, diarrhea, eye problems and miscarriages. The negative health implications of glyphosate are disputed, but it is becoming increasingly clear that it is a mix of glyphosate and the surfactants with which it is combined that may cause the health problems. In May 2007, Professor Paul Hunt, then **Special Rapporteur on the Right to Health** said, following a visit to Ecuador, "there exists credible and trustworthy evidence that aerial fumigation with glyphosate along the Colombia-Ecuador border damages the physical health" of

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the local population and that the activity "jeopardise[d] the enjoyment of the right to health in Ecuador."[1] The potential effect of aerial spraying on children was noted by the **UN Committee on the Rights of the Child**, which argued in 2006: "[W]hile acknowledging the State party's legitimate priority to combat narcotics, is concerned about environmental health problems arising from the usage of the substance glyphosate in aerial fumigation campaigns against coca plantations (which form part of Plan Colombia), as these affect the health of vulnerable groups, including children."[2] The former UN Special Rapporteur on the rights of indigenous people has also criticized this practice.[3]

Though the consequences to human health are a matter of some debate, the negative impacts of fumigation on food crops and the rainforest are beyond dispute. While coca can easily grow back, some types of food crops rarely do. It is a common sight to see a re-growing coca field surrounded by dead trees.

Forced Manual Eradication

Manual eradication involves teams of eradicators often accompanied by police or military who pull coca bushes from the ground. In the case of poppy, the stalks of opium plants are chopped and fields ploughed with tractors. In Peru, Bolivia and Colombia, as well as in Afghanistan, this has not proven to be effective. Moreover, the manner in which the programs are implemented has also involved human rights abuses. In Colombia, for example, many farmers report theft of food, livestock and other provisions by the eradication teams. There have also been reports of sexual violence, plunder and houses burnt to the ground.[4]

In Northern Laos, forced eradication campaigns were followed by rice shortages necessitating emergency aid.[5] UNODC research in Burma conducted in 2002 and 2003 in the Kokang Special Region I revealed that crop eradication and strict enforcement of opium bans resulted in a 50 percent decrease in school enrollment and the closure of two-thirds of pharmacies and medical practitioners.[6]

Alternative Development

Alternative development programs are certainly the least problematic of the crop reduction measures and when implemented properly, have resulted in positive outcomes. They refer to initiatives to replace illicit crops with legal alternatives and are promoted by various UN agencies, notably the UN Office on Drugs and crime (the UN does not support forced eradication).

However even well-intentioned alternative development strategies have had disastrous consequences. They are often accompanied by or preceded by forced eradication. The main problem has been the wrong sequencing: In Laos and Burma "opium bans" were enforced before viable alternative livelihoods were in place.[7] Development assistance was woefully insufficient and really only started after the bans were in place. Furthermore, rubber was promoted as a cash crop in Laos and the Wa region of Burma/ Myanmar. However, it can take years for trees to produce rubber and lacking in the start-up capital, the farmers simply couldn't wait for the harvest.[8] This led to a humanitarian crisis requiring emergency food assistance.[9]

There have been various efforts aimed at reducing supply in Afghanistan, by far the world's leading opium-producing country. The Afghan government wisely planned to "target areas where alternative livelihoods exist."[10] However, eradication in action was very different from the plan. It was ultimately poor farmers who "lack political support, are unable to pay bribes, and cannot otherwise protect themselves"[11] that bore the brunt of the eradication campaign.[12] This occurred without there being sufficient alternatives in place for people to make a living.[13]

In the eastern province of Nangarhar, bans on cultivation, forced eradication, imprisonment of farmers and threats of NATO bombing campaigns did lead to a reported decrease in production but it also resulted in a 90 percent drop in incomes for many, internal displacement and migration to Pakistan.[14]

In Colombia, alternative development programs have been hindered by lack of infrastructure. As one NGO expert put it, "We are expecting them to produce tons of fruit and vegetables to transport on trucks they do not have, on roads that literally do not exist, to sell in globalized markets against which they cannot compete."[15] Licit crops have also been sprayed and destroyed.

It is well recognized that for alternative development programs to succeed they need to be properly sequenced (alternatives must be in place before the illicit crops are removed); accompanied by investment in infrastructure; and supported by trade justice initiatives. Perhaps most importantly, they must have the consent and co-operation of local farming communities. Assistance for alternative development programs should also not be made conditional on illicit crop reductions.

Eradication has not worked

In all of the aforementioned examples, there have been negative consequences including subsequent food insecurity, denial of livelihood, displacement and other human rights concerns. It is also becoming increasingly clear that these measures have proven ineffective in limiting the production of illicit crops at all.

Since 2000, for example, the US congress has spent over half a billion dollars fumigating some 1.1 million hectares of Colombian land. However, the State Department estimates that there was a 6.4 percent increase in coca cultivation from 2006-2007 and a 22.6 percent overall increase since Plan Colombia began in 2000. According to UNODC, the number of Colombian households involved in coca cultivation increased from 67,000 in 2006 to 80,000 in 2007.[16]

Forced eradication has similarly failed to reduce opium poppy in Afghanistan. In June 2009, the United States announced plans to shift its policy in Afghanistan, recognizing, it seems, this failure. *"Spraying the crops just penalizes the farmer and they grow crops somewhere else,"* said Richard Holbrooke, Special Envoy to Afghanistan and Pakistan. *"The hundreds of millions of dollars we spend on crop eradication has not had any damage on the Taliban…On the contrary, it has helped them recruit. This is the least effective program ever."*[17]

Alternative development programs have certainly seen some successes, but without the basic infrastructure and market protections needed for the various programs, they are often doomed to fail. As noted by Flaviano Avila, a farmer in Guaviare, Colombia, "Until there is investment to change the foundation of our economy, people will continue to plant and replant coca, cutting down forests and doing what it takes to grow the only product that is easy to bring to market, always has a buyer, and generates an income to provide for a family."[18]

Furthermore, in Afghanistan, efforts to curb opium production had the opposite effect from what was intended. As noted above, eradication campaigns ended up focusing on smaller, vulnerable farmers without the political clout or financial wherewithal to protect themselves. Once they were removed, "large traffickers with substantial political control only consolidated their control over the drug industry."[19] Eradication has contributed to conflict, stimulated corruption, has mainly targeted the poorest of the poor, and has further contributed to the breakdown of the relationship between the population and the state.[20]

The lack of effectiveness of crop eradication is also evident in continued (and in some case increased) availability of cocaine, cannabis and heroin on the streets, as well as falling prices.

The balloon effect

Another illustration of the ineffectiveness of crop eradication efforts is the so-called "balloon effect." It is now well recognized and documented that when crops are eradicated in one area or region, the demand is met by those crops being grown elsewhere. This has been recognized as a side effect of drug control by the Executive Director of the UNODC.[21] The balloon effect has been seen across borders (for example opium poppy being significantly reduced in Burma only for the shortfall to be made up in Afghanistan) and within nations (for example, in Colombia, where since 1999 production has spread from 12 to 23 provinces[22]).

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2 UN Committee on the Rights of the Child, Concluding observations, Colombia, 8 June 2006, UN Doc No CRC/C/COL/CO/3 para 72.
3 Rodolfo Stavenhagen, following his mission to Colombia, UN Doc No E/CN.4/2005/88/Add.2, para 106 "Except where expressly requested by an indigenous community which has been fully apprised of the implications, no aerial spraying of illicit crops should take place near indigenous settlements or sources of provisions."
4 Witness for Peace and Association Minga, "Forced manual eradication: The wrong solution to the failed US counter-narcotics policy in Colombia," September 2008.
5 Martin Jelsma and Tom Kramer, "Withdrawal Symptoms, Changes in the Southeast Asian drugs market," Transnational Institute, August 2008, p 19.
6 Damon Barrett, Rick Lines, Rebecca Schleifer, Richard Elliot and Dave Bewley-Taylor, "Recalibrating the Regime: The Need for a Human Rights-Based Approach to International Drug Policy," The Beckley Foundation Drug Policy Programme, March 2008, Sec. 1:5.
7 Martin Jelsma and Tom Kramer, "Withdrawal Symptoms, Changes in the Southeast Asian drugs market," Transnational Institute, August 2008 p 2.
8 "Withdrawal symptoms," p 18.
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10 Transnational Institute, "Missing Targets, Counterproductive drug control efforts in Afghanistan," Drug Policy Briefing N. 24, September 2004 page 4.
11 D. Buddenberg and W.A. Byrd, "Afghanistan's Drug Industry," UNODC/World Bank, November 2006 .
12 Transnational Institute, "Missing Targets, Counterproductive drug control efforts in Afghanistan," Drug Policy Briefing N. 24, September 2007, page 4.
13 Transnational Institute, "Missing Targets, Counterproductive drug control efforts in Afghanistan," Drug Policy Briefing N. 24, September 2007 page 5.
14 Vanda Felbab-Brown, "U.S. Counternarcotics Strategy in Afghanistan," Testimony before the U.S. Senate Caucus on International Narcotics Control, 21 October 2009.
15 Sanho Tree, Director of the presentation at Bogota University, September 2009.
16 "An exercise in futility: Nine years of fumigation in Colombia," Witness for Peace, Fundacion Minga and Institute for Policy Studies, 2007 p. 1.
17 "US changes course on Afghan opium," *Christian Science Monitor*, 28 June 2009, http://www.csmonitor.com/2009/0628/p99s01-duts.html.
18 "An exercise in futility," p. 5.
19 Vanda Felbab-Brown, "U.S. Counternarcotics Strategy in Afghanistan," Testimony before the U.S. Senate Caucus on International Narcotics Control, 21 October 2009.
20 Transnational Institute, "Missing Targets, Counterproductive drug control efforts in Afghanistan," Drug Policy Briefing N. 24, September 2007, page 4.
21 "Making Drug Control Fit for Purpose: Building on the UNGASS Decade," UN Doc No E/CN.7/2008/CRP.17, March 7, 2008.
22 "An exercise in futility," p. 2.