Submission to the Expert Panel established pursuant to Commission on Narcotic Drugs (CND) resolution 68/6

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I. Purpose and structural failure

For more than three decades, the HIV Legal Network has advocated for evidence-based drug policy that upholds the human rights of people who use drugs, particularly in Canada and Eastern Europe and Central Asia (EECA), and repeatedly before UN bodies, including UN human rights treaty bodies and Special Procedures.

65 years after the adoption of the *1961 Single Convention on Narcotic Drugs*, the central question for the Expert Panel (Panel) should be whether the international drug control system achieves its foundational purpose: protecting the "health and welfare of humankind."[1] Our assessment is that it has not. While the conventions detail obligations to prohibit and punish certain conduct, including prohibitions on non-medical drug use, they feature weak mechanisms to guarantee healthcare, prevent HIV and hepatitis transmission, decrease toxic drug injury and death, and protect human rights. Governments have translated this framework into punitive policies that have fueled enormous harm, such as in Canada and EECA, where extensive evidence shows that reliance on drug prohibition carries significant financial and human costs, including by hampering the implementation and scale-up of essential harm reduction services.

The *1961 Single Convention* acknowledges the medical indispensability of controlled substances and requires attention to prevention, treatment, and rehabilitation (Articles 4 and 38). The *1971 Convention* likewise emphasizes the control of psychotropic substances while acknowledging their medical utility. Yet the penal provisions of the *1961 Convention* (Article 36) and the *1988 Convention* (Article 3) have supported extensive criminal law enforcement — in part because the conventions do not clearly acknowledge the legality of decriminalization and other non-punitive responses to drug use or confirm State obligations to uphold rights to life, health, security of the person, and non-discrimination. As recognized in the *International Guidelines on Human Rights and Drug Policy* and UNODC's legal analysis, the international drug control conventions provide flexibility for decriminalizing possession for personal consumption. Decriminalization has also been widely endorsed by UN human rights mechanisms, including treaty bodies and Special Procedures.

At the same time, and across all three treaties, provisions protecting access to healthcare and treatment lack systems to measure whether States reduce harms to health. Health and human rights commitments are thus treated as secondary aspirations, with little accountability for outcomes. The 2016 UN General Assembly Special Session, subsequent political commitments including CND Resolution 68/6, and the UN System Common Position on Drug Policy have acknowledged the central importance of health and human rights in international drug control. However, political declarations cannot by themselves address the entrenched enforcement of punitive drug laws, which deter people from seeking care, perpetuate stigma and precariousness, divert public resources from and impede the establishment and scale-up of vital services, and expose marginalized

[1] See preambular text of the 1961, 1971, and 1988 Conventions.

communities to surveillance, detention, incarceration, and family separation. Meanwhile, governments can claim strong treaty compliance while restricting services amid worsening health outcomes.

ii. **Country experiences**

In Canada, personal drug possession, drug sharing, splitting and supply remain criminal offences, with maximum penalties upon conviction ranging from seven years (for personal drug possession) to life in prison (for drug trafficking). Notably, following 12 consecutive years of decline, police-reported drug offences in Canada increased 13% from 2023 to 2024. Under Canada's drug control framework, lifesaving harm reduction interventions such as supervised consumption sites and drug-checking services require case-by-base federal exemptions to operate without the risk of criminal prosecution — an exceptional approach to health care which hampers their sustainability and scale-up. This is unacceptable in the context of an ongoing toxic drug crisis, which has killed more than 57,000 people in Canada since 2016 and injured many more — violating rights to life, health, and security of the person. Moreover, Black and Indigenous communities are racially profiled and disproportionately surveilled, charged, prosecuted, and incarcerated for drug offences[2] — further deprivations of their rights to non-discrimination and to freedom from arbitrary arrest and detention, as recognized by UN Special Procedures and human rights treaty bodies.

Ukraine demonstrates the limits of health investment without criminal law reform. Despite the substantial expansion of opioid agonist treatment (OAT), sterile injecting equipment, and HIV prevention, it continues to experience one of Europe's largest HIV epidemics. In 2025, 84.4% of people convicted of drug offences were convicted for possession without intent to supply, with criminalization reinforced by very low quantity thresholds. Ukraine's Drug Policy Strategy through 2030 acknowledges the need to move from criminal punishment toward health and social interventions, but its 2025–2027 operational plan contains no concrete legislative measures to decriminalize personal drug possession. According to an October 2026 analysis of successive national drug reports, recommendations to address criminalization and review drug-quantity thresholds included in the 2025 report were omitted from the 2026 report. This is not evidence that harm reduction fails; it is evidence that its benefits are constrained by punitive laws and practices, alongside other pressures including war and displacement.

[2] See, for example, Ontario Human Rights Commission, *From Impact to Action: Final report into anti-Black racism by the Toronto Police Service*, March 2024; A. Khenti, "The Canadian war on drugs: Structural violence and unequal treatment of Black Canadians," *International Journal of Drug Policy* 25 (2014) 190-195; R. Browne, "Black and Indigenous people are overrepresented in Canada's weed arrests," *Vice News*, April 18, 2018; A. Owusu-Bempah and A. Luscombe, "Race, cannabis and the Canadian war on drugs: An examination of cannabis arrest data by race in five cities," *International Journal of Drug Policy* (2020), 102937; K. Samuels-Wortley, "Youthful Discretion: Police Selection Bias in Access to Pre-Charge Diversion Programs in Canada," *Race and Justice* 1-24 (2019); D. Fumano, "New figures reveal the racial disparity in Vancouver drug charges," *Vancouver Sun*, August 7, 2020; S. Chu and G. Kolla, "Op-Ed: Take Toronto police out of the drug decriminalization equation," *NOW Toronto*, October 3, 2021; and R. Browne, "Exclusive Data Shows Canadian Cops Target More Black and Indigenous Folks for Drug Arrests," *Vice News*, April 19, 2022.

Russia illustrates the consequences of law enforcement institutions dominating drug policy decision-making. Its State Anti-Drug Committee is chaired by the Minister of Internal Affairs, while its strategy to 2030 frames drug control primarily as a national security concern. Criminalization, policing, and abstinence-oriented approaches have consequently prevailed over public health priorities. Despite decades of intense enforcement, Russia continues to experience one of the largest HIV epidemics in Europe and is a major contributor to the expanding HIV epidemic in EECA. OAT remains prohibited under Russian legislation, although the international drug conventions do not require this restriction. Russia has also actively promoted its prohibitionist model internationally, defending restrictive interpretations of the conventions. Its experience demonstrates how institutional reliance on law enforcement, coupled with rejection of evidence-based healthcare, can perpetuate the very public health harms that international drug control was intended to prevent.

iii. Recommendations

1. Operationalize existing UN health and human rights standards. The Panel should recommend that all relevant UN bodies, programmes, and agencies responsible for drug control, public health, and human rights actively promote and implement existing standards, including the UN System Common Position on Drug Policy, the *International Guidelines on Human Rights and Drug Policy*, and the 2026 UNAIDS guidance on decriminalization. Rather than developing additional guidance, these standards should be systematically incorporated into resolutions of the Commission on Narcotic Drugs (CND), UN policy positions, technical assistance, and country programmes. UN human rights treaty bodies and Special Procedures should address punitive drug laws through concluding observations, general comments, thematic reports, and country recommendations. Coordinated UN follow-up should ensure that these commitments inform national drug legislation, enforcement practices, and access to healthcare.

2. Promote decriminalization and proportionality in criminal legal systems. The Panel should recommend that the CND commit to broader consultations to amend the conventions, so they clearly establish the legality of harm reduction, decriminalization, and other non-punitive responses. At minimum, this should include explicit provisions to remove criminal and other punitive sanctions for drug use and possession for personal consumption, collective purchasing, and social sharing. Any personal use quantity thresholds should be realistic and indicative — not automatic grounds for trafficking charges. States should use existing treaty flexibility to establish alternatives to prosecution and imprisonment for minor, non-violent offences.

3. Remove barriers to health services and controlled medicines. The Panel should recommend that the CND call upon Member States to ensure non-discriminatory access to voluntary, evidence-based drug dependence treatment, OAT, regulated safer supply,

sterile drug consumption equipment, supervised consumption and overdose prevention services, drug checking, and HIV and hepatitis services — including in prisons. Relevant UN institutions should support States in removing legislative and administrative barriers to these interventions and improving access to essential controlled medicines.

4. Establish measurable accountability for the 2029 review. The Panel should propose that the CND adopt, before 2029, a common results framework assessing overdose morbidity and mortality, HIV and hepatitis transmission, coverage of harm reduction and voluntary treatment, access to controlled medicines, discriminatory policing, prosecution, and imprisonment. States should report the number of drug offences and the number of individuals prosecuted, distinguishing personal possession from trafficking, and publish race- and gender- disaggregated data on enforcement, sentencing, and incarceration. This helps assess whether national drug laws, budgets, and enforcement practices advance or undermine health and safety outcomes. The 2029 review should evaluate health and human rights results alongside, rather than subordinate to, traditional enforcement indicators.

5. Examine structural barriers and initiate treaty reform. More broadly, the Panel should recommend that the CND commission a time-bound assessment, inclusive of state and non-state actors and centering people who use drugs, of whether the 1961, 1971, and 1988 Conventions and the international drug control machinery prevent implementation of health and human rights obligations. This assessment should inform the 2029 review and identify changes that cannot be achieved through interpretation or national reform alone. Reforms should create measurable obligations concerning health, human rights, and equitable access to controlled medicines; give WHO and human rights institutions substantive roles in oversight; and make necessity and proportionality governing principles.