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**Annual report of the United Nations High Commissioner
for Human Rights and reports of the Office of the
High Commissioner and the Secretary-General**

**Follow-up to and implementation of the Vienna
Declaration and Programme of Action**

Study on the impact of the world drug problem on the enjoyment of human rights

Report of the United Nations High Commissioner for Human Rights*

Summary

In its resolution 28/28, the Human Rights Council requested the United Nations High Commissioner for Human Rights to prepare a study, in consultation with States, United Nations agencies and other relevant stakeholders, to be presented to the Council at its thirtieth session, on the impact of the world drug problem on the enjoyment of human rights, and recommendations on respect for and the protection and promotion of human rights in the context of the world drug problem, with particular consideration for the needs of persons affected and persons in vulnerable situations. The present report was prepared pursuant to the request of the Council.

* Late submission.

I. Introduction

1. In its resolution 28/28, the Human Rights Council requested the United Nations High Commissioner for Human Rights to prepare a study, in consultation with States, United Nations agencies and other relevant stakeholders, to be presented to the Council at its thirtieth session, on the impact of the world drug problem on the enjoyment of human rights, and recommendations on respect for and the protection and promotion of human rights in the context of the world drug problem, with particular consideration for the needs of persons affected and persons in vulnerable situations.

2. Requests for information were sent to States and other stakeholders. Submissions were received from 24 States, 4 United Nations agencies and other international organizations, 4 national human rights institutions and 35 non-governmental organizations.¹

3. Three treaties form the core legal framework of the United Nations international drug control regime: (a) the Single Convention on Narcotic Drugs of 1961 as amended by the 1972 Protocol, which brought plants such as cannabis, the coca bush and the opium poppy under international control; (b) the Convention on Psychotropic Substances of 1971, which did the same for synthetic substances and precursor chemicals used in manufacturing drugs; and (c) the United Nations Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances of 1988, which increased the scope of international policing of the drug trade and highlighted the connection between the drug trade and organized crime (see art. 3 (5)). These treaties bring hundreds of illicit substances under international control, criminalizing virtually every aspect of the unauthorized production and distribution of those substances, although production, distribution and possession for medical and/or scientific purposes is permitted.² While human rights are not specifically addressed in these treaties, the primary goal of the international drug control regime, as stated in the preamble of the 1961 Convention, is the protection of the health and welfare of humankind.

4. The International Narcotics Control Board oversees implementation of all three drug conventions. It monitors illicit drug production and trade, as well as access to controlled substances for scientific and medicinal purposes, and investigates States that do not comply with treaty requirements. The Commission on Narcotic Drugs classifies narcotic and psychotropic drugs under different levels of restriction; it also serves as a governing body of the United Nations Office on Drugs and Crime (UNODC) and approves the budget of the Fund of the United Nations International Drug Control Programme.

5. In its resolution 69/201, the General Assembly reaffirmed that the world drug problem must be countered in full conformity with the Charter of the United Nations and with full respect for all human rights. By its resolution 51/12, the Commission on Narcotic Drugs called for the promotion of human rights in implementing international drug control treaties, and the International Narcotics Control Board has stated that human rights must be taken into account when interpreting international drug control treaties. The Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health has argued that when the international drug control regime and international human rights law conflict, human rights obligations should prevail (see A/65/255, para. 10).

¹ The submissions are available from www.ohchr.org/EN/HRBodies/HRC/Pages/WorldDrugProblem.aspx.

² See Single Convention on Narcotic Drugs of 1961, art. 2 (5).

II. Right to health

A. Access to treatment

6. The right to health is provided for in article 12 of the International Covenant on Economic Social and Cultural Rights. Under articles 2 (2) and 3 of the Covenant, States are required to implement the right to health on a non-discriminatory basis, which includes extending that right to drug users.

7. The Special Rapporteur on the right to health has underlined the distinction between drug use and drug dependence. Drug dependence is a chronic, relapsing disorder that should be medically treated using a biopsychosocial approach. Drug use is neither a medical condition nor does it necessarily lead to drug dependence. People who use drugs and people who are dependent on drugs possess the same right to health as everyone else, and those rights cannot be curtailed if the use of drugs constitutes a criminal offence (see A/65/255, para. 7). The Special Rapporteur has noted that the same standards of ethical treatment apply to the treatment of drug dependence as to other health-related conditions, including with regard to the right of a patient to make decisions about treatment and to refuse treatment.

8. The Special Rapporteur has emphasized that health-care personnel have an obligation to provide treatment on a non-discriminatory basis and not to stigmatize or violate a patient's human rights. Nevertheless, people who use drugs may be subject to discrimination in health-care settings. People who inject drugs, for example, may have poorer access to health care in some countries, including for the treatment of HIV/AIDS. This may be due to unjustified restrictions by health-care providers on the provision of health care for people who inject drugs.³ The Special Rapporteur noted that care providers may not have adequate information or training concerning harm reduction measures (see A/65/255, para. 46). The World Health Organization (WHO) has recommended training health workers on issues of stigma and non-discrimination, to achieve better health outcomes.⁴

9. Individuals have sometimes been denied access to medical treatment on the grounds of their prior or current drug use, where evidence does not justify denial of treatment. Such denial has occurred on the rationale that a person's drug use would make him or her unable to adhere to treatment. The Special Rapporteur notes that adherence to medical treatment is not necessarily lower among persons who use drugs, and should be assessed on an individual basis (see A/65/255, paras 23-24).

10. Outreach programmes are useful in providing information and referral health services to drug users in the community. Information and education programmes can minimize harm to individuals who use drugs and encourage drug dependent persons to seek treatment.⁵

³ World Health Organization (WHO), United Nations Office on Drugs and Crime (UNODC) and Joint United Nations Programme on HIV/AIDS (UNAIDS), *Technical Guide for Countries to Set Targets for Universal Access to HIV Prevention, Treatment and Care for Injecting Drug Users* (2012), p. 26.

⁴ WHO, *Consolidated Guidelines on HIV Prevention, Diagnosis, Treatment and Care for Key Populations* (July 2014), pp. 96-99.

⁵ Submission of the Special Rapporteur to the Committee against Torture (19 October 2012), p. 6. Available from www.ohchr.org/Documents/Issues/Health/drugPolicyLaw.pdf.

B. Harm reduction

11. Harm reduction interventions aim to reduce the harms associated with the use of psychoactive drugs, without necessarily discouraging use. They include needle and syringe programmes, prescription of substitute medications, drug-consumption rooms, promotion of non-injecting routes for the administration of drugs, overdose prevention practices, and outreach and education programmes (see A/65/255, para. 50). Persons who inject drugs are at a heightened risk of contracting HIV, hepatitis B and C,⁶ and tuberculosis.⁷

12. The Committee on Economic, Social and Cultural Rights,⁸ the Committee on the Rights of the Child⁹ and the Special Rapporteur on the right to health have all determined that a harm reduction approach is essential for persons who use drugs. WHO, UNODC and the Joint United Nations Programme on HIV/AIDS (UNAIDS) promote harm reduction for injecting drug users.¹⁰ The Office of the United Nations High Commissioner for Human Rights has supported harm reduction and the Human Rights Council, in its resolution 12/27, recognized the need for harm reduction programmes.

13. Needle and syringe programmes involve the provision of sterile injection equipment to injecting drug users. WHO has endorsed the use of such programmes, noting that they reduce HIV infections substantially, in a cost-effective manner, without any major negative consequences.¹¹ Needle and syringe programmes eliminate contaminated needles, which reduces the risk of transmitting HIV and other blood-borne diseases such as viral hepatitis, in particular hepatitis B and hepatitis C (see A/65/255, para. 51).¹²

14. Opioid substitution therapy¹³ is an evidence-based approach involving the prescription of medications such as methadone or buprenorphine to treat opioid dependence. Opioid substitution therapy decreases the prevalence of injecting drug use and of sharing injecting equipment, thereby reducing the risk of contracting HIV and other blood-borne viruses, and is effective in managing withdrawal from opioids and preventing a relapse into drug use (see A/65/255, para. 52). WHO has recommended that all people from key populations who are dependent on opioids be offered and be given access to opioid substitution therapy.¹⁴

15. Drug overdoses, most of which involve opioids, are the main cause of drug-related deaths. Opioid substitution therapy reduces the use of drugs by injection and thus of overdosing by almost 90 per cent.¹⁵ The Special Rapporteur on the right to health and WHO have highlighted that first aid training for the administration of naloxone, which

⁶ WHO, *Guidance on Prevention of Viral Hepatitis B and C among People Who Inject Drugs*, policy brief (July 2012).

⁷ Harm Reduction International, *Global State of Harm Reduction 2012*.

⁸ See E/C.12/RUS/CO/5, E/C.12/ZAZ/CO/1, E/C.12/EST/CO/2 and E/C.12/UKR/CO/5.

⁹ In its general comment No. 15 (2013) on the right of the child to the enjoyment of the highest attainable standard of health.

¹⁰ WHO, UNODC and UNAIDS, *Technical Guide*, pp. 10-26.

¹¹ WHO, "Effectiveness of sterile needle and syringe programming in reducing HIV/AIDS among injecting drug users" (Geneva, 2004), p. 28, and WHO, *Consolidated Guidelines*, p. 4.

¹² WHO, "Four ways to reduce hepatitis infections in people who use drugs" (21 July 2012) and UNAIDS, *The Gap Report* (Geneva, 2014), p. 173.

¹³ Opioid substitution therapy is also referred to as opioid maintenance treatment, opioid agonist maintenance treatment or medication assisted treatment, according to WHO.

¹⁴ WHO, *Consolidated Guidelines*, p. 4.

¹⁵ WHO, *Community Management of Opioid Overdose* (Geneva, 2014), p. 3.

counters the effects of opioid overdose, can prevent overdose-related deaths and minimize the harm associated with drug overdose (see A/65/255, para. 54).¹⁶

16. Providing drug users with access to drug-consumption rooms can contribute to preventing the transmission of diseases and to reducing damage to the veins, as well as encourage users to make use of treatment and other services. Drug-consumption rooms have contributed to reducing overdose rates and increased access to medical and social services (see A/65/255, para. 54).

17. As of 2014, needle and syringe programmes had been implemented in 90 countries and opioid substitution therapy was available in 80 countries. However, needle and syringe programmes have been confirmed to be absent in 68 countries where drugs are injected. In 2014, it was reported that there were 88 drug-consumption rooms worldwide, of which only two were outside of Europe, Australia and Canada.¹⁷

18. The lack of needle and syringe programmes, in particular, has a direct impact on the spread of HIV. People who inject drugs account for approximately 10 per cent of all new HIV infections and for up to 30 per cent of new HIV infections outside sub-Saharan Africa. Worldwide, an estimated 12.19 million people inject drugs, of whom 1.65 million are living with HIV.¹⁸ WHO has estimated, on the basis of data from 49 countries, that the average risk of HIV infection is 22 times greater among people who inject drugs than among people in the general population; in 11 of those countries, the risk is at least 50 times higher.¹⁹

19. Among the benefits associated with harm reduction programmes is the increased entry into HIV/AIDS treatment programmes (see A/65/255, para. 57). UNODC, WHO and UNAIDS have recommended that a comprehensive package of harm reduction services be integrated into national AIDS programmes, both as an HIV prevention measure and to support adherence to antiretroviral therapy services and medical follow-up for people who use drugs.²⁰

20. One study compared countries that comprehensively and consistently adopted approaches based on harm reduction without punitive approaches with countries that steadfastly resisted the harm reduction programmes and focused instead on punitive approaches. It found that the prevalence of HIV among people who injected drugs in Australia, Germany, Switzerland and the United Kingdom of Great Britain and Northern Ireland was less than 5 per cent, whereas in the Russian Federation and Thailand HIV prevalence among people who injected drugs was over 35 per cent.²¹

C. Health care in prison

21. Drug use, including by injection, has been consistently documented to occur in prisons throughout the world. High rates of sharing injecting equipment leads to an elevated risk of transmitting HIV in prisons. Persons in custodial settings are entitled, without discrimination, to the same standard of health care found on the outside, including with regard to prevention, harm reduction and antiretroviral therapy. Continuity of care is critical

¹⁶ WHO, *Consolidated Guidelines*, p. 4.

¹⁷ Harm Reduction International, *The Global State of Harm Reduction 2014*.

¹⁸ UNODC, *World Drug Report 2015* (United Nations publication, sales No. E.15.XI.6), p. ix.

¹⁹ WHO, *Consolidated Guidelines*, p. 5.

²⁰ WHO, UNODC and UNAIDS, *Technical Guide*, pp. 10-21.

²¹ Global Commission on HIV and the Law, *HIV and the Law: Risks, Rights and Health* (New York, July 2012) and the United Nations Development Programme (UNDP), *Addressing the Development Dimensions of Drug Policy* (June 2015), p. 19.

for those entering places of detention and who have been receiving treatment such as opioid substitution and antiretroviral therapy or treatment for tuberculosis, as interrupting such treatment has serious health consequences.²²

22. The Special Rapporteur on the right to health has stated that if harm reduction programmes and evidence-based treatments are made available to the general public, but not to persons in detention, this contravenes the right to health. However, in 2014, while opioid substitution therapy was available in 80 countries, only 43 countries provided such therapy. He has also argued that, given the substantially higher health risks associated with incarceration, harm reduction programmes should be implemented and drug dependent persons should be treated so as to meet public health objectives, even if these services are not yet available in the community (see A/65/255, para. 60).

23. Health protection measures, including harm reduction measures, are effective in prisons and treatment programmes for people who use drugs, and are urgently needed in all prison settings.²³ Drug dependence treatment has also been noted to be highly effective in reducing crime, as treatment and care within prisons, or as alternatives to imprisonment, reduce rates of relapse, HIV transmission and recidivism.²⁴

D. Obstacles to achieving the right to health

24. The Special Rapporteur on the right to health has noted that drug users in States that criminalize drug use may avoid seeking health care for fear that information regarding their drug use will be shared with authorities, which could result in arrest and imprisonment, or in treatment against their will. The use of drug registries (lists of people who use drugs) may deter individuals from seeking treatment, especially given that violations of patient confidentiality have been frequently documented in States that maintain such registries (see A/65/255, para. 20, and A/64/272, para 23).

25. The Special Rapporteur has observed that criminalizing drug use and possession has led to risky forms of drug use designed to evade criminal prohibitions, which has in turn resulted in increased health risks for drug users. Risky forms of drug use may include the sharing of syringes and injection supplies, hurried or risky injecting and the use of drugs in unsafe places. The preparation of drugs in a hurry, to avoid detection by law enforcement officers, may increase the risk of overdose, vascular accidents and infections. The Special Rapporteur has noted that criminalizing drug use and possession may lead to an increased risk of illness, including from HIV infection, among people who use drugs (see A/65/255, paras. 25-26).

26. The Special Rapporteur has stated that these risks may be compounded by the drug user's reluctance, for fear of arrest, to seek health assistance in preparing and injecting drugs. He noted that criminalizing drug use increases the risk of drugs becoming contaminated with harmful or even deadly substances (see A/65/255, paras. 25-26). He added that criminalizing the dissemination of information, including on safe practices pertaining to drug use and harm reduction, is not compatible with the right to health because it hinders individuals' ability to make informed choices about their health.²⁵

²² WHO, UNODC and UNAIDS, *Technical Guide*, p. 26, and WHO, *Consolidated Guidelines*, p. 5.

²³ WHO Regional Office for Europe, *The Madrid Recommendation: Health Protection in Prisons as an Essential Part of Public Health* (Copenhagen, 2010), pp. 3-4.

²⁴ UNODC and WHO, "Principles of drug dependence treatment", discussion paper (2008), p. 14.

²⁵ Submission of the Special Rapporteur to the Committee against Torture (19 October 2012), p. 6.

27. The Special Rapporteur has observed that some States opposed to harm reduction measures have criminalized the carrying of needles, syringes and other drug paraphernalia,²⁶ in contravention of the *International Guidelines on HIV/AIDS and Human Rights*.²⁷ Fear of arrest and criminal sanctions may deter individuals from participating in needle and syringe programmes and from carrying sterile equipment, which increases the likelihood of using unsterile equipment and transmitting diseases. Legislation penalizing the carrying of such equipment, including by outreach workers, is a barrier to HIV control.²⁸ Promoting the use and supply of methadone, which is used in opioid substitution therapy, is a criminal offence in some countries.²⁹

28. WHO has recommended decriminalizing drug use, including injecting drug use, as doing so could play a critical role in the implementation of its recommendations on health sector interventions, including harm reduction and the treatment and care of people who use drugs.³⁰ UNAIDS too has recommended decriminalizing drug use as a means to reduce the number of HIV infections and to treat AIDS.³¹

29. The Special Rapporteur has identified many ways in which criminalizing drug use and possession impedes the achievement of the right to health. He has called for the decriminalization of drug use and possession as an important step towards fulfilling the right to health. He has noted that decriminalizing drug use cannot be equated with legalizing it. Decriminalization means that drug use and possession remain legally prohibited but that criminal penalties, if they are applied at all, are minor and of a non-custodial nature. Legalization, by contrast, involves no prohibition of the relevant conduct (see A/65/255, para. 62).

30. The Special Rapporteur has noted as positive the decriminalization experience in Portugal (see A/65/255, para. 64). In 2001, all drugs for personal use were decriminalized and drug use was characterized as an administrative offence. This was combined with an increased public health and social response to assist drug users. Portugal has not witnessed a material increase in drug use; in fact, indicators for certain groups show a decrease. Positive effects have included the destigmatization of drug users and the unburdening of the criminal justice system.³² The International Narcotics Control Board has indicated that the move to decriminalize drug use in Portugal was consistent with the 1988 Convention.³³ In total, 22 States have adopted decriminalization measures of one kind or another, although not always on the grounds of promoting public health.³⁴ The Special Rapporteur has indicated that decriminalization should be accompanied by an expansion in drug treatment programmes and drug education (see A/65/255, para. 67). On 26 June 2015, on the occasion of the International Day against Drug Abuse and Illicit Trafficking, the Secretary-General stated that consideration should be given to alternatives to criminalization and incarceration of people who use drugs and that there should be an increased focus on public

²⁶ Ibid.

²⁷ United Nations publication, sales No. E.06.XIV.4, p. 30.

²⁸ WHO, UNODC and UNAIDS, "Provision of sterile injecting equipment to reduce HIV transmission" policy brief (2004), p. 2.

²⁹ Harm Reduction International, *Global State of Harm Reduction 2014*.

³⁰ WHO, *Consolidated Guidelines*, p. 91.

³¹ UNAIDS, *The Gap Report*, p. 183.

³² Submission of Portugal. See Artur Domosławski, *Drug policy in Portugal: the Benefits of Decriminalizing Drug Use* (Warsaw, Open Society Foundations, 2011).

³³ *Report of the International Narcotics Control Board for 2004*, p. 80.

³⁴ Ari Rosmarin and Niamh Eastwood, *A Quiet Revolution: Drug Decriminalisation Policies in Practice across the Globe* (London, Release, 2012). Jamaica has decriminalized cannabis use (see the Dangerous Drug Amendment Act, 2015, para. 6, amending sect. 7C of the Act).

health, prevention, treatment and care, as well as on economic, social and cultural strategies. Decriminalization has been called for by a number of civil society organizations on the grounds that criminalization poses a major obstacle to public health responses to drug users and their right to health.³⁵

E. Access to essential medicines

31. In the preamble to the 1961 Convention, it is recognized that the medical use of narcotic drugs is indispensable for the relief of pain and suffering. Nevertheless, millions of people worldwide who require essential medicines for pain, drug dependency and other health conditions find that availability is often limited or absent. The Special Rapporteur on the right to health noted that access to these medications is often excessively restricted for fear that they will be diverted from legitimate medical uses to illicit purposes (see A/65/255, para. 41).

32. Restricting access to opioids affects not only the availability of opioid substitution therapy but also three unrelated areas where access to controlled medicines is essential: (a) management of moderate to severe pain, including as part of palliative care for people with life-limiting illnesses; (b) certain emergency obstetric situations; and (c) management of epilepsy (see A/65/255, para. 42).

33. In its general comment No. 14 (2000) on the right to the highest attainable standard of health, the Committee on Economic, Social and Cultural Rights stated that ensuring access to essential drugs, including opioids, is an essential element of the right to health and that States must comply with this obligation regardless of resource constraints. The Special Rapporteur has noted that access to controlled drugs is a critical part of the right to health and recommended that States increase access to controlled essential medicines (see A/65/255, paras. 40-47 and 76).

34. The International Narcotics Control Board has consistently found that availability of essential controlled medicines is too limited in many countries. In its 2014 annual report, the Board noted that approximately 5.5 billion people, or three quarters of the world's population, live in countries where access to medicines containing narcotic drugs is low or non-existent and have inadequate access to treatment for moderate to severe pain. The Board also noted that 92 per cent of the world's morphine (an opioid) is consumed by 17 per cent of the world's population, primarily in North America, Oceania and Western Europe. The Board and WHO have both recognized that unnecessarily restrictive drug control regulations and practices are a significant barrier to accessing essential controlled medicines.³⁶

³⁵ Submissions of the Global Commission on Drug Policy, pp. 3-5; Human Rights Watch, p. 2; the International Drug Policy Consortium, p. 5; Release, p. 8; and the Women's Harm Reduction International Network, p. 9.

³⁶ See *Report of the International Narcotics Control Board for 2014*, para. 12, and WHO, *Ensuring Balance in National Policies on Controlled Substances: Guidance for Availability and Accessibility of Controlled Medicines* (Malta, 2011).

III. Rights related to criminal justice

A. Prohibition of arbitrary arrest and detention

35. It has been alleged that police have sometimes targeted areas at or near drug treatment centres to make arrests.³⁷ These practices may be linked to how law enforcement success is measured in efforts to counter drug use, especially where the number of arrests for drug use has been used as an indicator of successful law enforcement activity. It has been reported that in some countries the police obtain the health information of people who are registered with drug dependence treatment clinics and use that information for law enforcement purposes (see A/65/255, para. 20).³⁸ In some countries, the police is reported to have targeted drug users to meet arrest quotas or to have harassed users for money or, in the case of women, sex.³⁹

36. The Working Group on Arbitrary Detention has found that people who use drugs are particularly at risk of arbitrary detention (see E/CN.4/1998/44/Add.2, paras. 81 and 97-99, and A/HRC/27/48/Add.3, paras. 111-119). Some States reportedly provide for automatic pretrial detention for persons arrested for drug use without examining the circumstances of each individual case, although the Inter-American Commission on Human Rights has declared this practice to be incompatible with human rights.⁴⁰ According to article 9 of the International Covenant on Civil and Political Rights, anyone arrested or detained on a criminal charge shall be promptly brought before a judge, which the Human Rights Committee has interpreted, in paragraph 33 of its general comment No. 35 (2014) on liberty and security of person, to mean a few days from the time of arrest, with 48 hours being ordinarily sufficient. There have been reports of persons detained for drug-related offences not being registered or promptly brought before a judge. In some States, an arrested person suspected of a drug-related offence can be kept in custody without being charged for a substantially longer time than a person detained for other offences can be.⁴¹

B. Prohibition of torture and other forms of ill-treatment

37. In some States, it has been reported that people who use drugs are subjected to violence during detention, often as a means of extracting confessions or obtaining information about other drug users or traffickers.⁴² The Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment and the Human Rights Committee have noted that some law enforcement agencies have intentionally withheld opioid substitution therapy from drug dependent suspects in custody to extract confessions or obtain information, a practice that they have found to constitute torture (see A/HRC/22/53, para. 73, A/HRC/13/39/Add.2, para. 85, and A/68/295, para. 68). The Special Rapporteur on torture has also found such a practice to be torture or ill treatment, in

³⁷ Submission of the Women's Harm Reduction International Network, p. 4.

³⁸ Submission of the Russian Civil Society Mechanism for Monitoring of Drug Policy Reforms in Russia, pp. 5-6.

³⁹ Global Commission on HIV and the Law, *HIV and the Law*, and submission of Eurasian Harm Reduction Network, p. 4.

⁴⁰ Submission of Centro de Estudios Legales y Sociales, Conectas Human Rights and Corporacion Humanas, p. 4, and Inter-American Commission on Human Rights, *Report on the Use of Pretrial Detention in the Americas* (2013), para. 137.

⁴¹ Submission of Centro de Estudios Legales y Sociales et al, pp. 5, 9 and 27.

⁴² François-Xavier Bagnoud Center for Health and Human Rights, *Health and Human Rights Resource Guide* (Harvard University, 2013), p. 4.9.

certain circumstances, even when it is carried out without the intention of obtaining information (see A/HRC/22/53, para. 74).

C. Right to life

38. Article 6 of the International Covenant on Civil and Political Rights provides that, in those States which have not abolished the death penalty, the sentence of death can only be applied for the “most serious crimes”. The Human Rights Committee has determined that drug-related offences do not meet the threshold of “most serious crimes” (see CCPR/C/IDN/CO/1, para. 10, CCPR/CO/84/THA, para. 14, and CCPR/C/SDN/CO/3, para. 19). The United Nations High Commissioner for Human Rights, the Special Rapporteur on torture, the Special Rapporteur on extrajudicial, summary or arbitrary executions, the Economic and Social Council, the General Assembly and the Secretary-General support this interpretation (see A/HRC/10/44 and Corr.1, para. 66, A/HRC/4/20, paras. 51-53, and A/HRC/24/18, para. 24).⁴³ The International Narcotics Control Board has encouraged States that impose the death penalty to abolish it for drug-related offences (see A/HRC/27/23, para. 31).

39. Nevertheless, it has been estimated that 33 countries or territories continue to impose the death penalty for drug-related offences, resulting in approximately 1,000 executions annually.⁴⁴ Drug-related offences account for the majority of executions carried out in some countries and are mandatorily punished by death in a number of States (see E/2015/49 and Corr.1, para. 72).⁴⁵

40. Human rights organizations have expressed concern about international funding and technical assistance for drug control programmes in States that retain the death penalty for drug-related offences.⁴⁶ UNODC, which opposes the death penalty, has stated that if “a country actively continues to apply the death penalty for drug offences, UNODC places itself in a very vulnerable position vis-à-vis its responsibility to respect human rights if it maintains support to law enforcement units, prosecutors or courts within the criminal justice system”. It noted that “at the very least, continued support in such circumstances can be perceived as legitimizing government actions. If, following requests for guarantees and high-level political intervention, executions for drug-related offences continue, UNODC may have no choice but to employ a temporary freeze or withdrawal of support”.⁴⁷ The European Union has emphasized that actions such as legal, financial or other technical assistance to third countries should not contribute to the use of the death penalty, and specifically indicated that the death penalty should not be imposed for drug-related crimes.⁴⁸

41. The Special Rapporteur on extrajudicial, summary or arbitrary executions has expressed concern about extrajudicial executions against people in the war on drugs (see A/HRC/26/36/Add.1, para. 8), a concern voiced also by States and non-governmental

⁴³ See also Economic and Social Council resolution 1984/50 and General Assembly resolution 39/118.

⁴⁴ Harm Reduction International, *The Death Penalty for Drug Offences: Global Overview 2012*, p. 5.

⁴⁵ See also the submission of Amnesty International, p. 2.

⁴⁶ Reprieve, Harm Reduction International, International Drug Policy Consortium, Transform, Release, Espolea, Drug Policy Alliance, Diogenis, Andrey Rylkov Foundation, Canadian Drug Policy Coalition and Forum Droghe, “INCB report launch and the death penalty for drug offences” (joint statement, 3 March 2015).

⁴⁷ UNODC, “UNODC and the promotion and protection of human rights” (2102), p. 10.

⁴⁸ Council of the European Union, “EU guidelines on the death penalty” (doc. No. 8416/13, annex).

organizations.⁴⁹ Impunity for extrajudicial killings is also a source of concern in operations aimed at the drug trade. The Special Rapporteur on torture has criticized ineffective investigations and relative impunity for actors alleged to have committed such human rights violations, and the United Nations High Commissioner for Human Rights has stressed the need for accountability for gross violations of human rights (see A/HRC/11/2/Add.2, paras. 33 and 53, and A/HRC/26/36/Add.1, paras. 81, 111 and 117).⁵⁰

D. Right to a fair trial

42. In some States, law enforcement responsibility for drug-related offences has been reportedly shared with or transferred to the military, often resulting in an excessive use of violence.⁵¹ It has been reported that people accused of drug-related offenses have been tried before military courts or special courts that may fall short of fair trial standards.⁵² Concerning the trial of persons in military or special courts, the Human Rights Committee has said that civilians should be tried in the ordinary courts, subject to narrowly defined exceptional circumstances, and that the protections of the International Covenant on Civil and Political Rights cannot be limited or modified because of the military or special character of the court.⁵³

43. In some States, it has been reported that accused persons may be given a choice between serving a sentence after conviction or submitting to drug treatment. Bearing in mind the right of a person to refuse treatment, this practice may be a cause for concern, in particular given the level of coercion involved.⁵⁴ Some States subject individuals to additional penal measures unless the treatment is successful, ignoring the particular circumstances of each individual's condition and that treatment for drug dependence has been characterized by medical professionals as often involving relapse on one or more occasions or requiring several types of treatment.⁵⁵ The Working Group on Arbitrary Detention has determined that when treatment is undertaken as an alternative to incarceration, under no circumstances may it extend beyond the period of the criminal sentence (see A/HRC/4/40/Add.2, para. 74).

44. Some States do not allow persons convicted for drug-related offences to be considered for suspended sentence, parole, pardon or amnesty that are available to those convicted of different crimes.⁵⁶ The Working Group on Arbitrary Detention has recommended that States amend their laws if they include provisions to that effect (see A/HRC/4/40/Add.3, para. 102 (c)).

⁴⁹ Submissions of Switzerland; the Mexican Commission for the Defence and Promotion of Human Rights, pp. 3-4; the Count the Costs Initiative, p. 7; and Human Rights Watch, pp. 2-3.

⁵⁰ See also the High Commissioner's opening statement at the twenty-seventh session of the Human Rights Council.

⁵¹ Submissions of Centro de Estudios Legales y Sociales, Conectas Human Rights and Corporacion Humanas, pp. 3 and 6-9; International Service for Human Rights and Peace Brigades International, p. 6; and the Mexican Commission for the Defence and Promotion of Human Rights, pp. 1-6.

⁵² Count the Costs, "The war on drugs: undermining human rights", p. 4.

⁵³ General comment No. 32 (2007) on the right to equality before the law and to a fair trial, para. 22.

⁵⁴ Global Commission on Drug Policy, *Taking Control: Pathways to Drug Policies that Work* (2014), p. 22.

⁵⁵ UNDP, *Addressing the Development Dimensions of Drug Policy*, p. 25, and the submission of Release, p. 2.

⁵⁶ Submission of Centro de Estudios Legales y Sociales, Conectas Human Rights and Corporacion Humanas, p. 27.

45. The focus on arresting and imprisoning drug users for possession or use small amounts has often resulted in prolonged pretrial detention, and persons convicted of drug-related offences frequently constitute a very high percentage of total prisoners in many countries. Mandatory sentencing and disproportionately long sentences for drug possession or use have often resulted in sentences longer than those for serious crimes such as murder, rape, kidnapping or bank robbery, and have contributed to overincarceration and prison overcrowding.⁵⁷ The Working Group on Arbitrary Detention has called for reform to ensure that sentences for drug-related offences are proportionate to the nature of the crime (see E/CN.4/2003/8/Add.3, paras. 44 and 72 (a), A/HRC/4/40/Add.4, paras. 47 and 87, and A/HRC/22/44/Add.2, para. 125). The Working Group has found that overincarceration for drug-related offences contributes significantly to prison overcrowding and that overcrowding can call into question compliance with article 10 of the International Covenant on Civil and Political Rights, which guarantees that everyone in detention shall be treated with humanity and respect for their dignity (see E/CN.4/2003/8/Add.3, para. 44, A/HRC/4/40/Add.3, para. 64, and A/HRC/4/40, paras. 59-80).

E. Human rights violations in compulsory detention centres

46. Persons who use drugs or who are suspected of using drugs may be confined in compulsory drug detention and rehabilitation centres without trial or an evaluation of their drug dependency, often for months or years, and frequently outside the supervision of the criminal justice.⁵⁸

47. Compulsory drug detention and rehabilitation centres, sometimes referred to as re-education through labour centres, typically subject detainees to long hours of physically strenuous exercise, physical and verbal abuse, beatings, solitary confinement and enforced labour, according to the Special Rapporteur on torture (see A/HRC/22/53, paras. 40-42). The Special Rapporteur on the right to health noted that these practices are not evidence-based and medical professionals who are trained to manage drug dependence are often inaccessible. Moreover, treatment is often conducted en masse and disregarding the need for informed consent to be given on an individual basis (see A/65/255, paras. 31-33).

48. Non-consensual experimental treatment, torture, ill-treatment and sexual violence have also been reported at compulsory detention centres (see A/HRC/22/53, paras. 40-42). Imposition of compulsory treatment, at the expense of not having access to opioid substitution therapy and other harm reduction interventions, also increases the risk of disease, particularly through HIV infection (see A/65/255, para. 36).

49. These practices have been condemned by 12 United Nations entities in a joint statement in which they call for the closure of compulsory detention centres.⁵⁹ Nevertheless, compulsory drug detention centres, many of which are located in East and South-East Asia, continue to detain approximately 235,000 people.⁶⁰

⁵⁷ Submissions of Colectivo de Estudios Drogas y Derecho; and Harm Reduction International and Penal Reform International, p. 1.

⁵⁸ Harvard FXB Center for Health and Human Rights and Open Society Foundations, *Health and Human Rights Resource Guide* (2013), p. 4.7. See also Open Society Foundations, *Treated with Cruelty: Abuses in the Name of Rehabilitation* (2011) and "Human rights abuses in the name of drug treatment: reports from the field" (2009).

⁵⁹ Available from www.unaids.org/sites/default/files/en/media/unaids/contentassets/documents/document/2012/JC2310_Joint%20Statement6March12FINAL_en.pdf.

⁶⁰ UNDP, *Addressing the Development Dimensions of Drug Policy*, p. 25.

IV. Prohibition of discrimination

50. Different forms of discrimination may result once an individual has a criminal record resulting from a conviction for a drug-related offence. These may include obstacles to obtaining employment, adverse effects on the custody of children or visitation rights, losing government benefits such as access to public housing, food assistance or student financial aid, or difficulties concerning travel abroad.⁶¹ This has been a factor in the decision by some States to decriminalize the personal use and possession of drugs.⁶² As former Secretary-General Kofi Annan said on 19 May 2015 at a side event on the theme “Strengthening a public health approach when addressing the world drug problem”: “A criminal record for a young person for a minor drug offence can be a far greater threat to their well-being than occasional drug use”.

A. Ethnic minorities

51. It has been reported that members of ethnic minorities, in particular those who are poor and live in marginalized communities, may be particularly subject to discrimination in the context of drug enforcement efforts. In the United States of America, for example, African Americans make up 13 per cent of the population, yet account for 33.7 per cent of drug-related arrests and 37 per cent of people sent to state prisons on drug charges. African Americans are 3.7 times more likely to be arrested for possessing or using marijuana than whites are, despite comparable usage rates. Similar disparities have been observed in countries such as Australia, Canada and the United Kingdom.⁶³ One law enforcement official observed that it was harder to intercept the sale and purchase of drugs in offices or affluent neighbourhoods than it was in poor and marginalized neighbourhoods, where such activity was often conducted in the street or other public areas and where police controls were more frequent.⁶⁴

B. Women

52. Globally, women are imprisoned for drug-related offences more than for any other crime. In several Latin American countries, 60-80 per cent of women in prison are incarcerated for drug-related offences.⁶⁵ In some States, women convicted of drug-related offences constitute the fastest growing part of the prison population. One in four women in prison in Europe and Central Asia is incarcerated for drug-related offences, with levels as high as 70 per cent in some countries. The Committee on the Elimination of Discrimination against Women has expressed concern at the number of women imprisoned for drug-related offences, observing that this may be indicative of women’s poverty (see CEDAW/C/UK/3 and 4). Women are typically involved in selling small quantities of drugs and are used as “mules” to carry small amounts of drugs from one country to another. Many of them are

⁶¹ Count the Costs, “The war on drugs: promoting stigma and discrimination”, pp. 3-5.

⁶² Rosmarin and Eastwood, *A Quiet Revolution*.

⁶³ Submissions of the Global Commission on Drug Policy, p. 6; and Harm Reduction International and Penal Reform International, p. 4.

⁶⁴ Count the Costs, “The war on drugs: promoting stigma and discrimination”, pp. 7-8.

⁶⁵ Corina Giacomello, “Women, drug offenses and penitentiary systems in Latin America” (International Drug Policy Consortium, 2013).

young, illiterate and single mothers who have to take care of their children and other family members.⁶⁶

53. It has been reported that women who use drugs may, depending on the laws and policies in force, face losing custody of their children, forced or coerced sterilization, abortion or criminal penalties for using drugs during pregnancy. In certain States, women who use drugs may be subject to detention during their pregnancy. Women who use drugs may not receive the appropriate care when they are pregnant.⁶⁷ WHO has published guidelines for the identification and management of substance use and related disorders during pregnancy.

54. Discrimination may exist in women's prisons where harm reduction, including opium substitution therapy, may not be available.⁶⁸ The Committee on the Elimination of Discrimination against Women has recommended that States provide gender-sensitive and evidence-based drug treatment services, including harm reduction programmes for women in detention, to reduce the harmful effects of drug use (see CEDAW/C/GEO/CO/4-5, para. 31 (e)). It has been reported that women who use drugs are often the targets of violence, including sexual violence, perpetrated by their partners and law enforcement officers. Women may be forced to have sex to avoid arrest or punishment by law enforcement officers.⁶⁹ Women who use drugs and who are also sex workers are reported to be even more vulnerable.⁷⁰

V. Rights of the child

55. Article 33 of the Convention on the Rights of the Child provides that States parties shall take all appropriate measures to protect children from the illicit use of narcotic drugs and psychotropic substances as defined in the relevant international treaties, and to prevent the use of children in the illicit production and trafficking of such substances.

56. In its general comment No. 3 (2003) on HIV/AIDS and the rights of the child, the Committee on the Rights of the Child noted that, in most countries, children have not benefited from HIV prevention programmes related to substance use and that, where HIV prevention programmes exist, they have largely targeted adults. It observed that injecting practices using unsterilized instruments increase the risk of HIV transmission and that programmes and policies aimed at reducing substance use and HIV transmission must recognize the particular sensitivities and lifestyles of children. In its general comment No. 15 (2013) on the right of the child to the enjoyment of the highest attainable standard of health, the Committee endorsed harm reduction as an important approach to minimizing the negative health impacts of substance abuse. It called for children to benefit from harm reduction programmes in its concluding observations (see CRC/C/UKR/CO/4, para. 59, CRC/C/AUT/CO/3-4, para. 51, and CRC/C/ALB/CO/2-4, para. 63 (b)).

57. The Committee has recommended that children receive accurate and objective information on drugs. It has called for children who use drugs not to be subjected to

⁶⁶ Count the Costs, "The war on drugs: promoting stigma and discrimination", pp. 8-9.

⁶⁷ Submission of the Women's Harm Reduction International Network, pp. 6-7.

⁶⁸ *Ibid.*, p. 5.

⁶⁹ Submission of the Open Society Institute, pp. 49-52. See also UNODC, the United Nations Entity for Gender Equality and the Empowerment of Women (UN-Women), WHO and the International Network of People Who Use Drugs, "Women who inject drugs and HIV: addressing specific needs" (2014).

⁷⁰ Submissions of the Women's Harm Reduction International Network, p. 8; and the Eurasian Harm Reduction Network, pp. 4-5.

criminal proceedings and for the possession of drugs by children to be decriminalized (see CRC/C/OPAC/MEX/CO/1, para. 29, and CRC/C/UKR/CO/4, paras. 59-60). However, the Committee found that, in practice, in most States children who use drugs are subject to criminal prosecution and often have no access to harm reduction and drug treatment services. The Committee criticized the aerial fumigation of drug crops because of its effects on children (see CRC/C/COL/CO/3, para. 72). It also condemned the practice of placing children in compulsory drug detention and rehabilitation centres (see CRC/C/KHM/CO/2, paras. 55-56).

VI. Rights of indigenous peoples

58. The 1961 Convention imposes restrictions on the cultivation of coca bush, opium poppy and cannabis plant for indigenous, traditional and religious uses, and requires that opium smoking be abolished within 15 years, that coca leaf chewing be abolished within 25 years and that cannabis use be abolished within 25 years at the latest (art. 49 (2)). The 1988 Convention requires States to criminalize the possession, purchase and cultivation of coca for personal consumption and to take measures to prevent the cultivation of and to eradicate illicit crops. In doing so, States must “take due account of traditional licit uses, where there is historic evidence of such use” (art. 14 (2)).

59. In 2009, the Permanent Forum on Indigenous Issues called for the amendment or repeal of those portions of the 1961 Convention regarding coca leaf chewing that are inconsistent with the rights of indigenous peoples to maintain their traditional health and cultural practices, as recognized in articles 11, 24 and 31 of the United Nations Declaration on the Rights of Indigenous Peoples (see E/2009/43-E/C.19/2009/14, para. 89).⁷¹ In 2011, the Plurinational State of Bolivia withdrew from the 1961 Convention, subsequently re-acceding to it with a reservation concerning the traditional practices associated with the coca leaf.⁷²

60. Some States have recognized exceptions to the application of the drug control treaties, including on grounds of religious belief. In the United States, the Native American Church is exempted from the prohibition on consuming peyote, a controlled substance, in religious ceremonies.⁷³ In Italy, a drug conviction was reversed on appeal because a lower court had not considered the arguments made by the Rastafarian defendant based on his religious convictions.⁷⁴ In Jamaica, the Government in 2015 changed its legislation to allow Rastafarians the right to use cannabis in their religious ceremonies.⁷⁵ Previous jurisprudence has tended not to permit the use of controlled drugs in religious ceremonies as a manifestation of religious beliefs, although sometimes with sharply divided views.⁷⁶

⁷¹ See also the International Labour Organization Indigenous and Tribal Peoples Convention, 1989 (No. 169), and the Convention for the Safeguarding of the Intangible Cultural Heritage.

⁷² See *Report of the International Narcotics Control Board of 2011*, paras. 270-280.

⁷³ See American Indian Religious Freedom Act Amendments of 1994, sect. 3 (a).

⁷⁴ Supreme Court of Italy, judgement No. 14876 (2012).

⁷⁵ The Dangerous Drug (Amendment) Act, 2015, para. 6, amending sect. 7C of the Act.

⁷⁶ See *Prince v. President of the Law Society of the Cape of Good Hope and Others*, Constitutional Court of South Africa (2002), in which four of the nine judges agreed that denying the petitioner access to the bar because of his religious cannabis use amounted to a disproportionate infringement on the religious freedom of the Rastafari, and CCPR/C/91/D/1474/2006.

VII. Conclusions and recommendations

61. The right to health should be protected by ensuring that persons who use drugs have access to health-related information and treatment on a non-discriminatory basis. Harm reduction programmes, in particular opioid substitution therapy should be available and offered to persons who are drug dependent, especially those in prisons and other custodial settings. Consideration should be given to removing obstacles to the right to health, including by decriminalizing the personal use and possession of drugs; moreover, public health programmes should be increased. The right to health requires better access to controlled essential medicines, especially in developing countries.

62. The prohibition of arbitrary arrest and detention, torture and other forms of ill-treatment and the right to a fair trial should be protected in accordance with international norms, including in respect of persons who are arrested, detained or charged for drug-related offences. Drug dependent persons in custodial settings should not be denied opioid substitution therapy as a means of eliciting confessions or other information, and opioid substitution therapy should be provided as part of a detainee's right to health in all circumstances. Compulsory detention centres should be closed.

63. The right to life of persons convicted of drug-related offences should be protected and, in accordance with article 6 of the International Covenant on Civil and Political Rights and the jurisprudence of the Human Rights Committee, such persons should not be subject to the death penalty. The right to life should be protected by law enforcement agencies in their efforts to address drug-related crime, and only proportional force should be used, when necessary. Extrajudicial killings should be subject to prompt, independent and effective investigations to bring the alleged perpetrators to justice.

64. Ethnic minorities and women who possess or use drugs, or who are "microdistributors", should be protected against discrimination. Consideration should be given to reforming laws and policies to address the disparate impact of drug policies on ethnic minorities and women. Providing training to law enforcement, health personnel and social service workers who come into contact with drug users should also be considered, to eliminate discrimination.

65. Taking into account the severe impact that a conviction for a drug-related offence can have on a person's life, consideration should be given to alternatives to the prosecution and imprisonment of persons for minor, non-violent drug-related offences. Reforms aimed at reducing overincarceration should take into account such alternatives.

66. The rights of the child should be protected by focusing on prevention and communicating in a child-friendly and age-appropriate manner, including on the risks of transmitting HIV and other blood-borne viruses through injecting drug use. Children should not be subjected to criminal prosecution, but responses should focus on health education, treatment, including harm reduction programmes, and social re-integration.

67. Indigenous peoples have a right to follow their traditional, cultural and religious practices. Where drug use is part of these practices, the right of use for such narrowly defined purposes should in principle be protected, subject to limitations provided for in human rights law.