THE BECKLEY FOUNDATION
DRUG POLICY PROGRAMME

RECALIBRATING THE REGIME

The Need for a Human Rights-Based Approach to International Drug Policy

REPORT THIRTEEN

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The Beckley Foundation Drug Policy Programme (BFDPP, www.internationaldrugpolicy.net) is a non-governmental initiative dedicated to providing a rigorous independent review of the effectiveness of national and international drug policies. The aim of this programme of research and analysis is to assemble and disseminate material that supports the rational consideration of complex drug policy issues, and leads to more effective management of the widespread use of psychoactive substances in the future. The BFDPP is a member of the International Drug Policy Consortium (IDPC, www.idpc.info), which is a global network of NGOs specialising in issues related to illegal drug use and government responses to the related problems. The Consortium aims to promote objective debate on the effectiveness, direction and content of drug policies at national and international levels.

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Executive Summary

Historically, policies aimed at prohibiting and punishing the use of certain drugs have driven the international approach to drug control and dominate the approach of most countries, guided as they are by the three UN drug control conventions and the dominant policy directions emanating from the associated international bodies. Such an approach is usually defended with moralistic portrayals that demonise and dehumanise people who use drugs as representing a 'social evil' menacing the health and values of the public and state. Portrayed as less than human, people who use drugs are often excluded from the sphere of human rights concern.

These policies, and the accompanying enforcement practices, entrench and exacerbate systemic discrimination against people who use drugs and result in widespread, varied and serious human rights violations. As a result, in high-income and low-income countries across all regions of the world, people who use illegal drugs are often among the most marginalised and stigmatised sectors of society. They are a group that is vulnerable to a wide array of human rights violations, including abusive law enforcement practices, mass incarceration, extrajudicial executions, denial of health services, and, in some countries, execution under legislation that fails to meet international human rights standards. Local communities in drug-producing countries also face violations of their human rights as a result of campaigns to eradicate illicit crops, including environmental devastation, attacks on indigenous cultures, and damage to health from chemical spraying.

At the level of the United Nations, resolving this situation through established mechanisms is complicated by the inherent contradictions faced by the UN on the question of drugs. On the one hand, the UN is tasked by the international community with promoting and expanding global human rights protections, a core purpose of the organisation since its inception. On the other, it is also the body responsible for promoting and expanding the international drug control regime, the very system that has led to the denial of human rights to people who use drugs. All too often, experience has shown that where these regimes come into conflict, drug prohibition and punishment has been allowed to trump human rights, or at least take human rights off the agenda. Directives from the UN General Assembly to carry out drug control activities in conformity with human rights have been all but ignored in the formation and execution of drug control policies and activities, even by other UN bodies involved in drug control. At the political level, the Commission on Narcotic Drugs (CND), the UN's inter-state body tasked with directing international drug policy, has never adopted a resolution with any operational requirements regarding human rights. In relation to UN programmes, as a result of control by the main donor states, spending on drug control by the UN Office on Drugs and Crime (UNODC), the secretariat that carries out the substantive work of the UN on drug control, is heavily weighted towards simple enforcement of drug control treaties, with little, if any, operational attention to the human rights dimensions of states' enforcement of these treaties or of their domestic drug legislation. Moreover, the International Narcotics Control Board (INCB), the monitoring body for the UN drug control conventions, has stated explicitly that it will not discuss human rights.

Yet even though there is little explicit regard for human rights in the UN drug control treaties, this does not mean the international regime is free to operate without complying with human rights law. UN bodies and UN member states are all bound by their overarching obligations under the *Charter of the United Nations* (Articles 1, 55 and 56) to promote 'universal respect for, and observance of, human rights and fundamental freedoms'. The Charter (Article 103) explicitly indicates that in the event of any conflict between states' obligations under the Charter and their obligations under any other international agreement, their Charter obligations shall prevail. According to former UN Secretary-General Kofi Annan, the new Human Rights Council was created to afford human rights 'a more authoritative position, corresponding to the primacy of human rights in the *Charter of the United Nations*'. Both he and his successor, Ban Ki-Moon, have stressed the importance of human rights, along with security and development, as one of the three pillars of the United Nations.

Despite the primacy of human rights obligations under the UN Charter, the approach of the UN system and the international community to addressing the tensions between drug control and human rights remains marked by an ambiguity that is inexcusable in the face of the egregious human rights abuses perpetrated in the course of enforcing drug prohibition.

2008 marks the 60th anniversary of the *Universal Declaration of Human Rights*, the bedrock of international human rights norms. Despite the actual and potential impact of the international drug conventions on human rights, the Universal Declaration is conspicuously absent from their preambles. It is past time for UN, its individual Members, and its organs, as well as civil society organizations, to ensure that the international drug control system works to respect, protect and fulfil the human rights of people who use drugs and affected communities, and to hold the international drug control entities and UN Members to account for human rights abuses committed in the name of drug control. The UN system needs to ensure coherence in its policy and programmatic approaches, a coherence that reflects the primacy and centrality of human rights to the rest of its work. In three parts, this report:

- presents a critical analysis of the UN systems of drug control and human rights, and their relative relationship within overall UN governance, and outlines the basis for the primacy of human rights;
- highlights the multiple ways in which the enforcement of drug prohibition, the dominant approach of the UN drug control system, leads to a wide and varied range of human rights violations; and
- sets out recommendations aimed at 'recalibrating the regime' to prevent the ongoing subversion of human rights protection in the name of drug control.

Part I - An Overview of the International Human Rights and Drug Control Systems

It is vital that the human rights and drug control entities are understood in the context of the larger UN governance system if dissonance within the UN system is to be addressed. Therefore, Part I provides an overview of the UN's international human rights and drug control systems, and their place within the UN system as a whole. While similar in structure, the principles and approaches reflected in each, and the machinery of each system, are quite different. *The Charter of the United Nations* creates a system of global governance both by setting out certain norms and creating mechanisms for implementing those norms. That governance system is fleshed out further through a wide range of additional instruments, including treaties on both human rights and drug control. This report reviews the basic normative structure of the UN, focusing on the position of drug control and human rights within that system. It then considers conflicts of ideology and law between these two systems in light of the hierarchy of the UN system as a whole.

As its primary legal document, the *Charter of the United Nations* creates the principal organs of the UN and sets out their mandates, and it binds UN member states to certain overarching principles and purposes. These include the obligation to promote solutions of international social, health and related problems, as well as universal respect for, and observance of, human rights and fundamental freedoms for all without discrimination. Created pursuant to the UN Charter, the General Assembly is the chief political body of the UN. The Economic and Social Council (ECOSOC) is responsible for the economic, social and related work of the UN and has created a number of functional commissions with responsibility for specific aspects of economic and social policy, including human rights and drugs. The Commission on Narcotic Drugs, the main political body on drug control and the UN, is one such functional commission and therefore reports to ECOSOC. The former Commission on Human Rights was replaced in 2006 by the Human Rights Council, a new 'standing body' that is elected by and reports directly to the Members in the General Assembly. It is now the central, and higher-level, political body at the UN dealing specifically with human rights. The work of the CND is supported by the UNODC as its secretariat, while the Office of the UN High Commissioner for Human Rights (OHCHR) acts as secretariat to the Human Rights Council and other elements of the UN's human rights system.

A range of treaties define further the drug control and human rights systems within the UN, again setting norms and creating mechanisms to support their implementation. A series of core human rights treaties — including the *International Covenant on Civil and Political Rights* (ICCPR), the *International Covenant on Economic, Social and Cultural Rights* (ICESCR), the *Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment* (CAT), and a range of conventions addressing the human rights of specific groups or concerns (such as women, migrant workers, children, people with disabilities, and racism) — elaborate on the fundamental human rights commitment of states under the UN Charter and articulated in the Universal Declaration of Human Rights. These treaties further legally bind states which ratify them to respect, protect and fulfil the rights they contain. A 'treaty body' of independent experts is tasked with monitoring states' progress towards meeting the obligations enshrined in each treaty, and reports regularly and directly to the General Assembly.

The treaty-based drug control system is similar in structure, though significantly smaller and very different in ideology, to the human rights treaty system. It is based on three international drug conventions: the *Single Convention on Narcotic Drugs* (1961) as amended by the 1972 *Protocol; the Convention on Psychotropic Substances* (1971), and the *Convention Against the Illicit Traffic in Narcotic Drugs and Psychotropic Substances* (1988). Each treaty encourages, and in some instances requires, criminal sanctions to be put in place at the national level. Many states have

adopted overly restrictive interpretations of such provisions, resulting in measures that are well beyond the treaty requirements. The fact remains, however, that the international drug control conventions are overwhelmingly prohibitionist in their approach and as such in favour of punishment and supply-side measures such as crop eradication and anti-trafficking law enforcement. Despite the concern for the 'health and welfare of mankind' noted in the preamble to the 1961 Single Convention, there are but a few provisions — albeit very open-ended ones — relating to the treatment of addiction in the 1961 and 1971 Conventions.

As is the case with the human rights treaties, an independent committee was established to monitor implementation of the drug treaties. The International Narcotics Control Board (INCB), a body of individuals acting in their personal capacities, was created by the 1961 Single Convention and is mandated to oversee implementation of all three of the drug conventions. The INCB plays a key role in monitoring the production and manufacture of illicit drugs and trafficking in those substances. However, it is also tasked with ensuring access to opiates for medicinal purposes, one of the primary aims of the 1961 Single Convention and an element of the right to health contained in a number of the human rights treaties. Unfortunately, the work of the INCB has been disproportionately in favour of the former. This is a reflection of the politics behind the conventions that has lead to an imbalance in its work, to the detriment of arguably the most important aspect of the international drug control system. The INCB's views and recommendations have also fallen out of step with UN policy and best practice on issues of global importance such as HIV prevention and human rights. The INCB's working methods are also out of step with the rest of the UN system, including the similarly constituted human rights treaty bodies. Its secrecy, its refusal to engage with civil society, and its dismissal of human rights are all the more troubling given that its work has significant impacts on the lives of those people who use drugs, people living with HIV and people who need access to medicinal and pain-relieving controlled drugs.

> The ideal of a 'drug free world' (to quote from the declaration adopted by the UN General Assembly in 1998), and its required prohibitionist, punitive approach, may be based on an overarching concern for the 'health and welfare of mankind.' But in practice, the health and welfare of those in need of special care and assistance — people who use drugs, those most at risk from drug related harm, and the most marginalised communities — have not been a priority. They have instead been overshadowed, and often badly damaged, by the pursuit of that drug-free ideal.

What, then, of the conflicts of ideology and of law between these two systems, in the larger governance structure of the UN? What happens if the requirements of one system run contrary to those of the other? Which system, human rights or drug control, should take precedence?

The international drug control system has been developed on the premise that a reduction in the illicit drug market can be achieved predominantly through prohibition-oriented supply side measures. Despite a stated concern in some of the drug control treaties for the 'health and welfare of mankind', this objective is not reflected proportionately in the terms of the treaties, which focus overwhelmingly on criminalisation and contain only limited provisions relating to treatment and rehabilitation for people who use drugs.

The international human rights system, however, is markedly different. In addition to the specific protections and freedoms set out in each human rights treaty, a number of key principles run throughout the conventions that are of considerable relevance to international drug control. First, the *principle of non-discrimination*, which requires states to avoid discriminating against certain individuals and groups on a variety of explicitly listed grounds as well as on the basis of 'other status' (which has been interpreted as including health status, including HIV status), and furthermore, to take positive measures to ensure that the rights of those in need of assistance are guaranteed. Despite these negative and positive obligations, examples of discriminatory policies against people who use drugs, and disproportionate application of criminal measures against indigenous peoples, ethno-racial minorities, and those living in poverty, are all too common. Similarly, enforcing criminal prohibitions against drugs often hinders access to health services and to medical treatment, which impact often falls disproportionately on these very groups, and on those living with illnesses such as HIV and hepatitis C or other health conditions.

A second, that of *protecting the most vulnerable*, is highly relevant to the situation of many people who use drugs, often some of the most marginalised in the community, and who are criminalised and stigmatised by the international drug control system. Third, the *principle of empowerment* runs throughout the human rights treaties. The drug conventions, however, are entirely silent on the active involvement of people who use drugs, key among those whose health and welfare are at stake and who bear the consequences of the drug control treaties, or the involvement of communities affected by drug use, production and trafficking or efforts to eliminate production (e.g., through crop eradication). Key to this empowerment is the involvement of civil society in governance, which is essential if human rights violations and progress on issues such as HIV prevention and drug use are to be addressed. However, while civil society engagement increases in the human rights system and other areas of the UN, the drug control system lags far behind, and in the case of the INCB, has been expressly rejected by some representatives.

None of these underlying principles are evident in the drug conventions, nor are they evident in the governance and monitoring structures in the drug control system. The result is a set of conventions that significantly affect people's lives yet lack a human face. These conventions are overseen by a machinery whose work intersects significantly with healthcare, development and law enforcement, but key parts of that system are reluctant or unwilling to discuss human rights. This lack of guidance has created a policy and legislative environment where drug control activities often infringe on human rights protections.

Yet this is contrary to the basic structure and normative hierarchy of the UN. Protection of human rights is clearly, specifically and repeatedly identified as one of the purposes of the UN in the Charter, and as a specific legal obligation of all UN member states, whereas drug control has been conceived from the outset as a subset of the higher aims of the Organisation and its Members. Furthermore, the Charter's own provisions make it clear that Charter obligations take precedence over other, conflicting treaty obligations. The principal recommendation-making body of the UN, the General Assembly, has specifically stated that drug control 'must be carried out in full conformity with the purposes and principles of the *Charter of the United Nations* and other provisions of international law, and in particular with full respect for… all human rights and fundamental freedoms, and on the basis of the principles of equal rights and mutual respect.' If a principal organ of the UN directs that drug control must be in conformity with human rights, then this must be reflected in the operations of the UN. Human rights violations stemming from drug control must be highlighted and brought to an end, and the drug control machinery must adopt a rights-based approach to its work in order to avoid complicity in human rights abuses and to influence domestic implementation of the international drug control conventions in line with human rights norms. Instead, notwithstanding the de jure precedence of human rights obligations over drug control, de facto drug control is prioritised over human rights. This raises a serious concern for UN system coherence and the commitment of the Organisation, and of member states, to the protection and promotion of human rights and the aims of the UN Charter.

Part II – Drug Law, Policy and Prejudice: The Impact on Fundamental Human Rights

The influence of the international drug control conventions at the national level should not be underestimated. All three have been very widely ratified, and are invoked regularly by national governments to justify highly punitive — and often human rights-violating — measures, as well as the failure to take action to protect and fulfil the human rights of people who use drugs. Human rights abuses that emerge as the result of drug enforcement policies, laws or activities — including denial of harm reduction interventions such as methadone or access to sterile injecting equipment — have been well documented. In both high-income and low-income countries across all regions of the world, human rights have been allowed to become a casualty of the 'war on drugs'. The consequences of prioritising the criminalisation of drugs and people who use them over protecting and promoting health have come into even starker focus in the context of the global HIV pandemic. The policy approaches of the drug conventions, as interpreted and implemented by many states, stand as significant barriers to HIV prevention and treatment efforts among injecting drug users, further impeding realisation of the right to the highest attainable standard of health.

Despite this damaging influence at the national level of the interpretation and application of the UN drug control treaties, there has been little condemnation from the UN drug control machinery of such abuses. Silence from the UN drug control entities could run the risk of UN complicity in those violations: the OHCHR has noted that an organisation may be complicit in violations of human rights if it 'tolerates, or knowingly ignores' those abuses. It is therefore vital that human rights violations stemming from drug control continue to be documented and brought to the attention of the international community, and that the UN, at all levels, is held to account for its human rights obligations under the Charter.

But condemnation of abuses is not enough. There has been a conspicuous lack of policy guidance on human rights compliant drug policies in the implementation of the international drug conventions. Such top-down policy guidance from the UN is essential if human rights violations at the national level are to be pre-empted and prevented and positive human rights impacts maximised. Part II examines some examples of those human rights violations occurring at the national level in the name of drug control.

Law enforcement

Violence and summary execution: In February 2003, the government of **Thailand** launched a violent and murderous 'war on drugs', the initial three-month phase of which resulted in some 2,275 extrajudicial killings. In November 2007, the Thai Office of the Narcotics Control Board disclosed that some 1,400 people killed had no link to drugs at all. In **Brazil**, police are engaged in an increasingly violent and frequently lethal war on drugs. Despite the high concentration of people in the country's *favelas* (shanty towns), armed police have

engaged in open gunfire with drug gangs in an effort to stem the traffic in drugs and arms. Children recruited into drug trafficking gangs are considered legitimate targets for armed police and are shot at without hesitation. In the first half of 2007, official police figures recorded 449 killings in such confrontations, with another sixty police officers losing their lives. Extrajudicial killings by police are common, and impunity for such crimes is almost total.

Arrest and ill-treatment of drug users: People who use drugs make especially easy targets for arrest or ill-treatment by police needing to fulfil arrest quotas, as Human Rights Watch has documented in reports on **Russia**, **Kazakhstan**, and **Ukraine**. In addition, the need to fulfil arrest quotas or achieve convictions may encourage police to engage in torture or other abusive tactics to extract confessions from criminal suspects. Police also use drug addiction as a tool to coerce incriminating testimony from drug users. It has been reported, for example, that in **Ukraine** police intentionally use withdrawal as an investigative tool to coerce incriminating testimony from drug users, extort money from drug users by threatening to detain them, forcing them to suffer withdrawal and deny medical assistance to drug users going through withdrawal. The UN Committee against Torture has expressed concern about 'the numerous convictions based on confessions' in Ukraine. In the **United Kingdom**, The Drugs Act 2005 allows for compulsory drug testing for those arrested for certain 'trigger offences', including theft and persistent begging, despite the fact that the tests are not intended to prove or disprove the commission of an offence. Even if the person is found to have not committed the offence for which they were arrested, an order for compulsory drug assessment may still stand.

Death penalty for drug offences: The death penalty for drug offences is a violation of international human rights law, yet more than thirty countries retain capital punishment for drugs. In **Malaysia**, between July 2004 and July 2005, thirty-six of the fifty-two executions carried out were for drug trafficking. The government of **Viet Nam** stated in a 2003 submission to the UN Human Rights Committee that 'over the last years, the death penalty has been mostly given to persons engaged in drug trafficking'. Around 100 people are executed by firing squad in Vietnam each year, mostly for drug-related offences. Since 1991, more than 400 people have been executed in **Singapore**, the majority for drug offences. In recent years, China has used the UN's International Day Against Drug Abuse and Illicit Drug Trafficking (26 June) to conduct public executions of drug offenders. In 2002, the day was marked by sixty-four public executions in rallies across the country, the largest of which took place in the south-western city of Chongqing, where twenty-four people were shot. Amnesty International recorded fifty-five executions for drug offences over a two-week period running up to 26 June 2005.

Demand reduction

Detention and coercive drug treatment: In **China**, the law states that 'drug users must be rehabilitated.' Those arrested for drug possession and use can be consigned to forced detoxification centres without trial. Once inside, detainees are required to perform unpaid, forced labour and are also subject to mandatory testing for HIV and other sexually transmitted infections and to militarised psychological and 'moral education'. Investigations have uncovered extreme ill-treatment in the name of 'rehabilitation', such as the administering of electric shocks while viewing pictures of drug use. In **Thailand**, during the 2003 'war on drugs' the government mandated that all drug users attend drug treatment. Those that did not 'volunteer' for treatment were subject to arrest and compulsory treatment. According to experts, scores of Thais – some drug users, some not – reported for drug treatment during the war simply because they believed it was the only way to avoid arrest or possible murder.

Supply reduction

Forced crop eradication: Research conducted in 2002/2003 by the UNODC on the Kokang Special Region 1 in **Myanmar (Burma)** found that illict crop eradication led to a 50% drop in school enrolment, and that two of every three pharmacies and medical practitioners shut down. Those conducting the research concluded that the rapid elimination of the farmers' primary source of cash income caused 'economic and social harm to the region.' A UN study in **Peru** came to a similar conclusion. In evaluating the impact of a palm-oil project in Aguaytía, the UNODC concluded in a 2005 report that in areas where coca production was widespread, farmers reported that their quality of life fell following the voluntary eradication program. In **Afghanistan**, the dangers of forced eradication prior to the provision of alternative livelihoods are even greater. Poppy cultivation provides some two million farmers with an estimated USD 500 million annually in subsistence income, with several hundred million more provided to wage labourers. In 2005, the World Bank warned that 'an abrupt shrinkage of the opium economy or falling opium prices without new means of livelihood would significantly worsen rural poverty.' Decades of forced eradication efforts in Latin America have left a trail of social conflict, political unrest, violence and human rights violations. In **Bolivia**, for example, U.S.-backed counter-drug efforts led to a disturbing pattern of killings, mistreatment and abuse of the local population and arbitrary detentions by members of local security forces. Government efforts to meet coca eradication targets set by Washington led to massive protests, in which both government forces and coca growers have been killed. These potential negative consequences are even greater when aerial herbicide spraying is undertaken. There is ample reason for concern that spraying causes serious harm to the environment and human

health, both immediately and in the long-term. In its 2006 report on **Colombia**, the Committee on the Rights of the Child noted it was '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'. The damage often inflicted upon licit food crops – and hence food security for a very vulnerable segment of the population – is also cause for concern.

Drug Control Undermining HIV Prevention, Treatment, Care and Support

Harm reduction: Research in several countries has established that criminal laws proscribing syringe possession and associated policing practices targeting drug users increase the risk of HIV and other adverse health outcomes in both direct and indirect ways. The fear of arrest or police abuse creates a climate of fear for drug users, driving them away from lifesaving HIV prevention and other health services, and fostering risky practices. 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. Police presence at or near government sanctioned harm reduction programmes (such as legal needle exchange sites) drives drug users away from these services out of fear of arrest or other punishment. In **Thailand** studies reported a significant decline in the number of people seeking treatment for drug use during the war on drugs, and that a significant percentage of people who had formerly attended drug treatment centres went into hiding. Interviews with peer educators and people who inject drugs involved in HIV prevention projects along the border of **China** and **Viet Nam** indicated that 'crackdowns and elevated enforcement activities' led to the arrest of many IDUs and drove others underground or prompted them to leave the area.

Prisons, harm reduction and the right to health: Given the illegal nature of drugs and the punitive approaches to drug use, many people who use drugs find themselves incarcerated at some point in their lives, often cycling in and out of custody over many years. People do not surrender their fundamental rights when they enter prison. On the contrary, prisoners retain all rights and freedoms guaranteed under international human rights law, except for those that are necessarily restricted by virtue of being incarcerated. Nonetheless, upon incarceration, many opioid-dependent prisoners are forced to undergo abrupt opioid withdrawal. Forced or abrupt opioid withdrawal can cause profound mental and physical pain, have serious medical consequences, and increase the risk of suicide among opioid-dependent individuals with co-occurring disorders. Others may continue to use, or initiate the use of, opiates while in prison. In this context, the lack of access to harm reduction measures such as needle and syringe programmes in most prison systems means that people who inject drugs must share and/or reuse injecting equipment, thereby increasing the risk of transmission of HIV, Hepatitis C and other blood-borne viruses.

Discrimination

Access to antiretroviral treatment: A recent study by WHO Europe showed that in many countries, access to antiretroviral treatment (ART) for people who use drugs is not proportionate to HIV rates among them, with **Eastern European countries** having the lowest rates of access in the region. The figures showed that while there were significant improvements in access to antiretrovirals in western European countries from 2002-2005, in eastern Europe, more than 70% of reported HIV cases were in the IDU transmission category between 2002 and 2005, but the rates of access to HAART increased from only 14% to 38%. These figures are mirrored in other parts of the world. In **China**, figures from 2006 showed that while 48% of HIV cases were injecting drug users, only 1% of those on ART were people who inject drugs. In **Malaysia**, the figures were 75% of HIV cases versus 5% of access to ART. In **Russia**, where people who use drugs dominate the population in need of antiretroviral treatment, they have often been systematically excluded from government AIDS treatment programmes. In **Ukraine**, which has the worst HIV/AIDS epidemic in Europe, and where, like Russia, people who use drugs represent the majority of people living with HIV, drug users have also faced significant obstacles to antiretroviral therapy. In June 2005, the Global Fund to Fight AIDS, Tuberculosis, and Malaria raised the concern that 'IDUs (injection drug users) remain a group of people significantly unable to access treatment in Ukraine.' **Thailand**, which has been globally regarded as a leader among developing countries in providing antiretroviral therapy, has failed to systematically extend treatment to people who use drugs. In 2004, Thailand amended national guidelines that had until then excluded active drug users from eligibility for treatment.

Drug user registries: Some jurisdictions place people who seek or are required to attend drug dependence or health care treatment on a state registry. Drug user registries act as a barrier to health care and drug treatment by discouraging people from seeking treatment and permitting or fostering both real and perceived breaches of confidentiality. In some cases, for example, state clinics and doctors routinely share this information with law enforcement agencies. **Russian** narcological clinics require all drug users who seek free treatment at state drug dependence treatment clinics to be placed on a state drug user registry. Public hospitals in **Thailand** register information about active drug users on a database that is available to law and drug enforcement officials, and national and local Ministry of Health Officials, and to members of the district committees, which include police. In **Malaysia**, all patients on government methadone programmes and

those sent to compulsory treatment must be registered and in Vietnam, the names are kept by community focal points and passed on to the Department of Social Evils and the National Drugs Committee

Denial of access to essential services: Discrimination in access to services extends beyond ART and harm reduction. In the **United Kingdom**, for example, active injecting drug users are often refused treatment for hepatitis C virus (HCV), despite official guidance to the contrary. Many consultants will test, but will not treat active injectors. A Human Rights Watch study on human rights and HIV/AIDS in the **Ukraine** found that '[D]iscrimination and abuse against drug users is persistent in health care settings…Drug users and service providers working with them said that some medical facilities refused altogether to provide care to drug users, and that treatment, when provided, was inadequate, and provided in an abusive manner'. Human Rights Watch also interviewed a number of active drug users who had treated themselves for serious abscesses caused by injecting having been refused medical treatment. In **Sweden**, women with severe alcohol or drug problems are usually not given access to shelters if they face domestic violence.

Discriminatory application of drug control: The impact of drug control is often disproportionately focussed on vulnerable groups and marginalised communities. The victims in the majority of the human rights violations documented above are not the major drug traffickers, drug 'barons' or 'kingpins'. Rather, they are the peasant farmers, small time dealers, low level drug offenders and, overwhelmingly, people who use drugs. The majority are poor. They are black, ethnic minorities or indigenous peoples. Given the ways in which drug law enforcement has hindered access to HIV prevention and care services, they are often disproportionately people living with HIV. In countries across the world, supply-side and law enforcement driven drug policy has been allowed to overshadow socio-economic root causes of problematic drug use and involvement in drug related crime. A key element of the right to non-discrimination, however, is the positive obligation to identify those groups and individuals in need of special care and assistance to ensure that their rights are guaranteed. In the **United States** research by Human Rights Watch has shown that African-American men are sent to prison on drug charges at 13.4 times the rate of white men. Furthermore, 62.7% of all drug offenders admitted to state prison were African-American, compared with 34.7% white. As noted by Human Rights Watch 'but for the war on drugs, the extent of black incarceration would be significantly lower'. In **Brazil**, the vast majority of those killed by police in their ongoing war against drugs are poor, black, young boys from favela communities, for whom involvement in the drug gangs is one of the few viable opportunities for employment. As one favela resident commented 'They've a lack of hope because everything is so difficult. They already live in a place where nothing's good [...] and they already have that coexistence [with the traffickers...]. In their view they think that trafficking is the easiest option'.

Justifiable Violations? Human rights restrictions and the principle of proportionality

Most rights may be restricted or lawfully infringed, subject to very specific justifications. They may not be arbitrarily curtailed. A fundamental principle in this regard is that any measures taken must be proportionate. In other words, they must be no more than is necessary to achieve a legitimate aim. This paper describes mass crop eradication campaigns that ignore cultural uses of those crops, damage food crops and adversely affect the health of local communities; forced treatment programmes which amount to detention without trial; and the denial of vital services including HIV prevention and care solely on the basis of status as a drug user. It also describes disproportionate sentences, such as the death penalty for drug offences. Such measures are entirely disproportionate to the aim of controlling drug production and use. Moreover, as a growing body of research casts doubt on the link between harsh enforcement of drug laws, and reduced levels of drug use or problems, it is getting harder for states to justify such penalties in terms of their necessity to achieve wider social objectives. The question must be asked – if a measure fails to achieve its 'legitimate aim' can it ever be considered 'necessary' to achieve that aim?

Part III – Human Rights Violations or a Rights-Based Approach? The Need for Greater System-Wide Cohesion

International human rights law – based in the *Charter of the United Nations*, the Universal Declaration and numerous international treaties – provides an avenue to address the historic and systemic weaknesses, inadequacies and inequalities in the international drug control system, and to work to prevent further violations and the application of disproportionate measures such as those described above. More than a mere counter-balance to drug control treaties, human rights law occupies a position of much greater legal authority. Indeed, in order to bring the drug control system of the United Nations into conformity with the organisation's obligations as set out under the Charter, human rights must be seen not simply as a tool to redress specific abuses, but as a lens through which all drug control efforts must be filtered. Therefore, what is required, if the aims of the UN are to form the basis of drug control, and if specific human rights abuses are to be prevented, is a human rights-based approach to drug control policies and activities.

A number of factors are essential if a human rights-based approach to drug control is to be achieved.

1. Leadership on human rights from the CND: The member states of the CND must undertake specific resolutions mandating that UN drug control policy be conducted in accordance with human rights law and with the aim of furthering human rights protections. As a first step, the CND should adopt a resolution recognising the Universal Declaration's applicability to all of its work, and committing the Commission to furthering the aims of the UN and protecting and promoting fundamental human rights. Given the paralysis induced by the current practice of operating only by consensus, the first test in demonstrating leadership will be for individual member states willing to break with convention and call a vote for progress on human rights.

2. A human-rights-based approach to UNODC programmatic work: As the lead UN agency on drug control programmes and HIV prevention connected to injecting drug use, UNODC is extremely well placed to make a positive difference in the promotion and protection of human rights in the context of drug control. CND should therefore, by way of resolution, direct that UNODC adopt a human rights-based approach to its work in accordance with the aims of the UN and human rights law. Human rights principles must guide all drug control activities and programmes, including assessment and analysis, programme planning and design (including setting goals, objectives and strategies), implementation, monitoring and evaluation. To achieve this:

- The strategy must aim to **mainstream human rights through UNODC organisational strategies**, by making explicit reference to its human rights obligations as a UN agency and ensuring that the promotion and protection of human rights is integrated throughout its own work and at the national level in the formulation and implementation of drug control policies.

- The CND should adopt a resolution instructing UNODC to develop **human rights impact assessments** for all current and future programmes, through collaboration with the OHCHR.

- Specific **human rights indicators** should be developed to measure of UNODC's success or failure on its human rights obligations. The UNODC should report on this aspect of its work at each CND session.

- **Reject the stigmatising language** frequently used by UN bodies (such as the INCB) that only contributes to discrimination and other human rights violations against people who use drugs and violations of their human rights, and instead adopt language recognising that people who use drugs are often those in need of care and assistance to protect their health and human rights.

- **Undertake greater joint planning and co-working between the UNODC and the OHCHR** to ensure that human rights principles take centre stage in drug control operations and that such operations do not hinder or contradict human rights efforts.

3. Greater focus on human rights violations stemming from drug control from the human rights bodies in the UN: The UN human rights treaty bodies, special procedures, and the Human Rights Council need to ensure greater focus in their work on human rights violations caused by drug control efforts, and develop guidelines to ensure that human rights requirements in the context of drug control are fully understood. Given the devastating link between HIV and problematic drug use, and the human rights violations linked to each, the Human Rights Council, as the main political entity with responsibility for human rights, should appoint a **Special Rapporteur on HIV/AIDS and human rights**. This would provide an opportunity for strengthening the guidance found in the *International Guidelines on HIV/AIDS and Human Rights*. The Rapporteur's mandate could include reporting on the connection between HIV/AIDS and the human rights of drug users and on measures that hinder or help efforts at HIV prevention, treatment, care and support among drug users.

4. Donor accountability: Given their legal obligations flowing from the UN Charter and their ratification of various human rights treaties, donor countries to UNODC should therefore support human rights impact assessments to ensure that their own human rights obligations are not breached through their financial support of oppressive drug control operations. Donor states should also consider making unrestricted donations so that the current imbalance in expenditure between law enforcement and HIV prevention may be addressed.

5. Meaningful civil society engagement at CND: As the CND's governing body, ECOSOC should mandate greater opportunities for meaningful civil society engagement in the work of the CND, learning from examples of civil society engagement elsewhere in the UN system and develop some guidelines for that participation.

6. Reform of the INCB, to bring its practices into line with similarly constituted bodies within the UN system, is badly needed as is clarification of its views on harm reduction and human rights in line with the aims of the United Nations. In general, the INCB needs to operate more transparently, and open up its processes to civil society engagement; enhance its focus on availability and quality of treatment for chemical dependence; develop greater expertise on HIV, public health and human rights; and recognise the legitimacy of less restrictive interpretations of the drug control treaties of which it is guardian. An independent review of the INCB to ensure greater accountability would be advisable.

Conclusion

The wide range of examples included in this report, in which human rights standards and norms are potentially or actually infringed as a result of state activities pursued in the name of drug control, demonstrate clearly the need for close attention to this issue within the UN system. It is therefore remarkable, particularly in the context of a reform process that seeks system-wide cohesion, that:

- Human rights are rarely mentioned, or given serious consideration, in the policies and programmes of the UN drug control system.

- Human rights abuses against people who use drugs or local farming communities are rarely mentioned, or given serious consideration, within the standard setting or inspection programmes of the UN human rights apparatus.

- Despite clear strategic commitments to ensure the co-ordination of their programmes with other relevant UN agencies, the OHCHR and the UNODC have made no serious efforts towards joint strategic planning or programme development.

This state of affairs should not be allowed to continue - the health, welfare and human rights of millions of people depend on the adoption, by national governments and international agencies, of drug policies that achieve an appropriate and effective balance between the need to tackle drug markets and the obligation to protect the rights of everyone affected by them. The status quo will only lead to further violations of human rights in the name of drug control.

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