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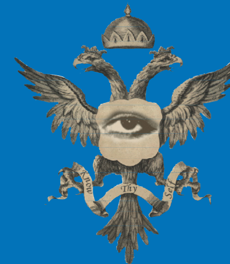

RECALIBRATING THE REGIME
The Need for a Human Rights-Based Approach to International Drug Policy

REPORT THIRTEEN

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WATCH

This report was produced in partnership with the International Harm Reduction Association (IHRA), Human Rights Watch (HRW), and the Canadian HIV/AIDS Legal Network (CHALN)

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

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.

RECALIBRATING THE REGIME

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

INTRODUCTION

Writing in 1996, Professor Norbert Gilmore of McGill University in Montreal observed that, '[L]ittle has been written about drug use and human rights. Human rights are rarely mentioned expressly in drug literature and drug use is rarely mentioned in human rights literature.'[1]

More than ten years later, campaigning NGOs, legal advocates and organised groups of people who use drugs are increasingly invoking human rights norms in their work. Yet it remains the case that, in most countries, drug policy and legislation[2] are rarely informed by international human rights obligations, and drug issues rarely enter into the discourse of human rights mechanisms and monitors, at either the national or international level.

It is within this vacuum that human rights abuses against people who use drugs occur with little public comment, despite the fact that violations as a direct consequence of drug policy and drug enforcement have arguably grown wider and more severe since Gilmore's article was written.

Yet with a few notable exceptions, the mainstream human rights movement has done little on commenting, let alone campaigning, on human rights abuses that result from drug control activities. This despite the fact that domestic and international drug enforcement policies and practices intersect directly with issues on which human rights advocates have typically been very vocal – abusive law enforcement practices, extrajudicial killings, mass incarceration, capital punishment, indigenous rights and HIV/AIDS, to name but a few.

Punitive, prohibitionist policies drive the international approach to drugs and dominate the approach of most countries, guided as they are by international drug policies, in particular the UN drug control conventions.[3] These policies, and the resulting enforcement practices, are typically justified on moralistic grounds,[4] which serve to entrench and exacerbate systemic discrimination against people who use drugs, and to fuel human rights violations around the world.

The moralistic perspective portrays the drug trade not as criminal activity, but rather as a social evil'[5] or a 'global menace'.[6] Persons involved in the drug trade are not mere criminals, but rather 'merchants of death',[7] 'engineers of evil'[8] or 'peddlers of death'[9] whose actions cause 'serious harm to the nation'.[10] Indeed, one of the core UN drug control treaties, the Single Convention on Narcotic Drugs 1961, refers, in its preamble, to the 'evil of drug addiction'.[11] People who use drugs, similarly, are portrayed as morally suspect or socially dead [12], described in media accounts as 'ghosts,' 'devils,' or 'animals'. Portrayed as less than human, drug users are thus assumed to be undeserving of human rights[13]. Indeed, some policymakers have recommended that they be treated like drugs: as things to be isolated, controlled and contained. Drug offenders are painted as threats to the life, values and health of the public and the state, against whom extraordinary penalties are therefore justified. For example, Malaysian Prime Minister Datuk Seri Abdullah Ahmad Badawi has described that country's use of death penalty for drugs as the 'right kind of punishment' given the menace that drugs pose to society.[14]

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 execution, 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 rights as a result of crop eradication campaigns, including environmental devastation, attacks on indigenous cultures, and damage to health due to chemical spraying.

1 N Gilmore, 'Drug Use and Human Rights: Privacy, Vulnerability, Disability, and Human Rights Infringements' (1996) 12 *Journal of Contemporary Health Law & Policy* 355, p. 356.

2 For a resource equipping advocates and law-makers to pursue legislation and policy related to drugs that is based on human rights norms, see Canadian HIV/AIDS Legal Network, 'Legislating for Health and Human Rights: Model Law on Drug Use and HIV/AIDS' (2006), www.aidslaw.ca/modellaw (Date of last access: 14 February 2008).

3 A number of states have interpreted the international drug conventions to allow for less punitive approaches, such as decriminalisation of cannabis possession, safe injecting sites and heroin prescription, but such examples are very much in the minority. See N Dorn & A Jamieson, 'Room for Manoeuvre; Overview of comparative legal research into national drug laws of France, Italy, Spain, the Netherlands and Sweden and their relation to three international drug conventions' A study of DrugScope, London, for The Independent Inquiry on the Misuse of Drugs Act 1971 (2000); and .K Krajewski 'How Flexible are the United Nations drug conventions?' (1999) *International Journal of Drug Policy*, 10, pp. 329-338.

4 MT Aoyagi 'Beyond Punitive Prohibition: Liberalizing the Dialogue on International Drug Policy' (2005) 37 *NYU J Int'l L & Pol* 555, p. 585.

5 *Ong Ah Chuan v Public Prosecutor* [1980—1981] AC 648 para. 64 (Privy Council).

6 AH Geraghty 'Universal Jurisdiction and Drug Trafficking: A Tool for Fighting one of the World's Most Pervasive Problems' (2004) 16 *Fla J Int'l L* 371, p. 374.

7 M Hor 'Singapore's Innovations to Due Process' (2000). Paper presented at the International Society for the Reform of Criminal Law's Conference on Human Rights and the Administration of Justice, Johanesburg, p. 9.

8 Malaysia Chief Justice Azlan Shah cited in SL Harrington 'Death, Drugs and Development: Malaysia's Mandatory Death Penalty for Traffickers and the International War on Drugs' (1991) 29 *Colum J Transnat'l L* 365, p. 380.

9 ibid.

10 1995 US report to the Human Rights Committee cited in Schabas WA 'The Federal Death Penalty and International Law' (2001) 14 *Fed Sent R* 32 s. 3.

11 Preamble, Single Convention on Narcotic Drugs, 1961.

12 Daniel Wolfe 'Paradoxes in antiretroviral treatment for injecting drug users: Access, adherence and structural barriers in Asia and the former Soviet Union', International Journal of Drug Policy 18 (2007) 246-254 p. 252 (Hereafter Paradoxes in antiretroviral treatment)

In some cases, the steady erosion in human rights protections for people who use drugs is a measurable phenomenon. For example, over the past twenty years the number of countries practicing capital punishment has declined remarkably. As described by Professor William A. Schabas, an internationally renowned scholar on the death penalty, 'Few more dramatic examples of the spread and success of human rights law can be found.'[13] However, the international status of the death penalty for drug-related offences stands in sharp contrast to this abolitionist trend. While the number of countries practicing capital punishment has steadily decreased over the past twenty years, of those that maintain it in some form, the number of countries expanding the scope of death penalty legislation to include drugs has steadily increased. More countries than ever before allow capital punishment for drug offences, and in many of these countries drug offenders comprise a significant percentage of executions each year. Therefore, if the progress towards the abolition of capital punishment is indeed a dramatic example of the success of human rights law, then the expansion of capital punishment for drugs illustrates an example of a dramatic exception – one that has received scant comment even within the international movement to abolish the death penalty.

On the one hand, UN bodies, both political and programmatic, are tasked by the international community with promoting and enforcing global human rights protections, a core purpose of the organisation since its inception. On the other, UN entities are also responsible for promoting and expanding the international narcotics control regime, the very system that not only encourages the denial of human rights to people who use drugs, but also provides ideological justification for those abuses.

All too often, experience has shown that where these regimes come into conflict, drugs prohibition has been allowed to trump human rights, or take human rights off the agenda. For example, over the past ten years, the UN General Assembly has regularly stated in resolutions that international drug control must be carried out in conformity with the *Charter of the United Nations*[16] and 'in particular…with full respect for human rights'.[17] However, this directive from the General Assembly has 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 making recommendations on international drug policy, has never acted upon the General Assembly's requirements in this regard. To date, human rights have received only passing mention in preambular paragraphs of CND resolutions dealing with HIV prevention, with no corresponding operational requirements. In relation to UN programmes, while the UN Office on Drugs and Crime (UNODC) is an agency that deals with a wide variety of issues, from human trafficking to corruption, spending on drug control by the UNODC is disproportionately in favour of law enforcement with little, if any, operational attention to the human rights dimensions of states' enforcement of these treaties or of their domestic drug legislation. As the UNODC relies on voluntary contributions from member states for almost 90% of its funding and the bulk of that funding is restricted to specific projects, this imbalance is largely a representation of the interests of the main donor states to the UNODC. Moreover, the International Narcotics Control Board (INCB), the monitoring body for the UN drug control conventions, has even said specifically that it will 'not discuss human rights'.[18]

While the human rights norms are absent from the preambles of the three UN drug control treaties, this does not mean the UN narcotics control regime is free to operate without complying with human rights law. Indeed, article 14(2) of the Convention Against the Illicit Traffic Narcotic Drugs and Psychotropic Substances 1988 states that measures undertaken to eradicate illicit crops must 'respect fundamental human rights'.[19]

More importantly, however, the UN, its agencies and member states are bound by their overarching obligations under articles 1, 55 and 56 of the Charter of the United Nations to promote 'universal respect for, and observance of, human rights and fundamental freedoms'.[20] Under article 103 of the Charter, 'In the event of a conflict between the obligations of the Members of the United Nations under the present Charter and their obligations under any other international agreement, their obligations under the present Charter shall prevail.'[21] This means that international treaties on narcotics control must be interpreted so as to comply with the overarching duty to respect and observe human rights.[22]

13 Daniel Wolfe 'Alchemies of Inequality: The United Nations, Illicit Drug Policy and the Global HIV Epidemic', in Kasia Malinowska-Sempruch, S Gallagher (Eds) War On Drugs, HIV/AIDS and Human Rights, International Debate Education Association, New York (2004)158-189 (Hereafter Alchemies of Inequality)

14 M Hussein 'Abdullah Defends Death Penalty For Drug Traffickers', Bernama Malaysian National News Agency (22 February 2006).

15 WA Schabas 'International Law, Politics, Diplomacy and the Abolition of the Death Penalty' (2004) 13 *Wm & Mary Bill Rts J* 417, p. 419.

16 Charter of the United Nations, June 26, 1945, 59 Stat. 1031, T.S. 993, 3 Bevans 1153, *entered into force* Oct. 24, 1945. (Hereafter Charter of the United Nations).

17 See GA Res 61/183 (13 March 2007) UN Doc A/RES/61/183, para 1.; GA Res 60/178 (22 March 2006) UN Doc A/RES/60/178, para 1.

18 Mr Koli Kouame, Secretary of the INCB, Press Conference, New York, 7 March 2007. Webcast available at http://157.150.195.10/webcast/pc2007.htm (Date of last access: 14 February 2008).

19 Convention Against the Illicit Traffic in Narcotic Drugs and Psychotropic Substances 1988, U.N. Doc. E/CONF.82/15 (1988), reprinted in 28 I.L.M. 493 (1989) art. 14(2) (Hereafter 1988 Convention).

20 Charter of the United Nations art 55. Article 1 states that a purpose of the United Nations is 'To achieve international cooperation in solving international problems of an economic, social, cultural, or humanitarian character, and in promoting and encouraging respect for human rights and for fundamental freedoms for all without distinction as to race, sex, language, or religion'.

21 Ibid., art 103

22 See 'Fragmentation of International Law: difficulties arising from the diversification and expansion of international law: Report of the Study Group of the International Law Commission', UN Doc A/CN.4/L.702, 18 July 2006, para 35. (Hereafter Fragmentation of International Law).

On 10 December 2007, the United Nations launched a year long, UN system-wide celebration of the 60th anniversary of the *Universal Declaration of Human Rights*.[23] The Universal Declaration stands as the bedrock of international human rights norms yet it is conspicuously absent from the preambles of the international drug control treaties. Though not legally binding, the preambles convey the spirit of the conventions and set the tone for international drug policy. As instruments of international law that have the potential for considerable impacts on human rights, the absence of any mention of the Universal Declaration is significant. It is time to advocate for an international drug control system that 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 member states to account for human rights abuses carried out in the name of drug control.

PART I

An Overview Of The International Human Rights And Drug Control Systems

Never before have we needed strong and well-functioning multilateral institutions as we do today. Without them we cannot achieve our common global objective to free all people from fear, want and indignity.[24]

All UN agencies and programmes must further support the development of policies, directives and guidelines to integrate human rights in all aspects of the UN's work.[25]

The human rights and drug control systems in the United Nations are very similar in structure. Both have focused political bodies made up of UN member states. Both are supported by the UN Secretariat to carry out the substantive work, and both incorporate a consensual, treaty-based system overseen by independent committees. This does not mean to suggest, however, that the working methods adopted in both systems are the same, or that the principles or ideologies they enshrine are compatible. Furthermore, this structural similarity does not equate to an equal status in law or an equal status for their respective political bodies in the UN governance system.

In order to assess human rights violations stemming from international drug control and the resulting dissonance in the United Nations system, it is important to begin with an overview of that system, of the human rights and drug control machinery within it, and of the principles and approaches each adopts. Without this broader perspective, UN system coherence cannot be achieved on human rights, and UN governance relating to human rights protection will continue to be subverted in the name of drug control.

This first section therefore looks at both the human rights and drug control systems within the UN from the perspective of the UN Charter and the governance mechanisms it creates, and the relevant international treaties that strengthen and set out the normative content for both systems. It then goes on to consider conflicts of ideology and law between the two legal systems and hierarchies in UN governance.

23 Universal Declaration of Human Rights, G.A. res. 217A (III), U.N. Doc A/810 at 71 (1948) (Hereafter Universal Declaration of Human Rights).

24 Statement by the President of the UN General Assembly, H.E. Mr Jan Eliasson, First Session of the Human Rights Council, 19 June 2006, available at http://www.un.org/webcast/unhrc/statements/hrc060619pgae.pdf (Date of last access: 10 January 2008).

25 Recommendation of the Secretary-General's High-level Panel on UN System-wide Coherence in the Areas of Development, Humanitarian Assistance, and the Environment. 'Delivering as One: Report of the Secretary-General's High-level Panel', 9 November 2006, p. 27.

Charter-Based Systems

Human Rights and Drug Control under the Charter of the United Nations

The Charter of the United Nations is the primary legal document in the UN system. It creates the Principal Organs of the United Nations and sets out their mandates, and it binds the UN to certain overarching principles and purposes.

Article 55 of the Charter, mirroring article 1, states that:

with a view to the creation of conditions of stability and well-being which are necessary for peaceful and friendly relations among nations…the United Nations shall promote:

a higher standards of living, full employment, and conditions of economic and social progress and development;

b. solutions of international economic, social, health, and related problems; and international cultural and educational cooperation; and

c. universal respect for, and observance of, human rights and fundamental freedoms for all without distinction as to race, sex, language, or religion.

Both the human rights and drug control systems in the UN have, as their basis, the achievement of (at least some of) these aims.

Article 56 of the Charter goes on to state that all UN members 'pledge themselves to take joint and separate action in co-operation with the Organization for the achievement of the purposes set forth in Article 55'.[26] This provision is reinforced and recognised as a fundamental human right by article 28 of the *Universal Declaration of Human Rights*, which 'gives expression' to the human rights requirements of the Charter,[27] and guarantees 'the right to a social and international order in which the rights set forth in this Declaration can be fully realized'.[28]

The General Assembly and ECOSOC

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. Two of the primary entities in the Charter-based system are the General Assembly and the Economic and Social Council (ECOSOC). Both are Principal Organs of the United Nations[29] and both have central and senior roles to play in relation to human rights and drug control.

The General Assembly is comprised of all 192 UN member states and is the chief political body in the UN. It plays a key role in standard-setting and in codifying international law, and its resolutions form the basis of international policy to further the aims of the Charter.[30]

Article 10 of the Charter states that the General Assembly 'may discuss any questions or any matters within the scope of the present Charter or relating to the powers and functions of any organs provided for in the present Charter'. Article 13.1(b) relates this specifically to human rights, stating that the General Assembly may initiate studies and make recommendations aimed at 'promoting international cooperation in the economic, social, cultural, educational, and health fields, and assisting in the realization of human rights and fundamental freedoms for all without distinction as to race, sex, language, or religion'.

The Economic and Social Council is responsible for the economic, social and related work of the UN. Its fifty-four members are elected by the General Assembly, and it is mandated to ensure that recommendations of the General Assembly that fall within its competence are carried out.[31] Article 62 of the Charter places human rights and economic, social and health related problems within the competence of ECOSOC.

The Charter requires that ECOSOC 'set up commissions in economic and social fields and for the promotion of human rights, and such other commissions as may be required for the performance of its functions'.[32] In its first session in 1946, it therefore created the Commission on Human Rights and the Commission on Narcotic Drugs, among other 'Functional Commissions'.[33]

26 Charter of the United Nations, art 56.

27 'Explanatory Note by the Secretary-General on the Human Rights Council', UN Doc A/59/2005/Add.1, para. 7.

28 Universal Declaration of Human Rights, art 28.

29 Charter of the United Nations, art 7.

30 See http://www.un.org/ga/about/background.shtml (Date of last access: 3 January 2008).

31 Charter of the United Nations art 67.

32 ibid., art 68.

33 For a list of existing Functional Commissions see http://www.un.org/Docs/ecosoc/subsidiary.html (Date of last access: 6 February 2008).

Commission on Narcotic Drugs

The Commission on Narcotic Drugs (CND) is the central political body on drugs in the UN system.[34] As a 'Functional Commission', it is elected by and reports to the member states of ECOSOC. Comprising fifty-three member states, the CND meets annually, adopts resolutions on drug policy and may propose new international treaties relating to drugs or amendments to the current treaties. It serves as the governing body for the UN Drug Control Programme (UNDCP) within the UN Office on Drugs and Crime (UNODC), and drafts resolutions for adoption at ECOSOC. The CND also has responsibilities under the international drug control treaties (see further below), and serves as the preparatory body for the UN General Assembly Special Sessions on Drugs (UNGASS).

Each of the CND's roles may have a considerable impact on human rights in the context of international drug control. For example, the CND has mentioned human rights in very few resolutions, and then only in preambular paragraphs to resolutions dealing with HIV prevention. As the governing body for the UN Drug Control Programme housed within the UN Office on Drugs and Crime, it is the CND's job to provide policy guidance to the lead body in the UN dealing with drugs and HIV/AIDS and the body that implements UN drug control programmes. A lack of human rights guidance from CND, given the potential and actual human rights abuses stemming from drug control operations, is therefore of considerable concern. CND currently operates on the basis of consensus among member states and civil society engagement is minimal. Both are significant barriers to the promotion of human rights in the context of drug control.[35]

The Human Rights Council

The Commission on Human Rights (CHR), established at the same time as the CND in 1946, was replaced in 2006 in order to afford human rights a more senior position within the UN consistent with its prominence in the Charter. The CHR was replaced by a new 'standing body', the Human Rights Council, which is elected by and reports directly to the General Assembly. The Council is now the central political body at the UN dealing specifically with human rights, and assumed all of the responsibilities of the former CHR. The Human Rights Council may also hold special sessions on issues of particular concern if two-thirds of its forty-seven member states agree, and oversees the new Universal Periodic Review Procedure.[36]

The Human Rights Council is mandated to oversee the 'Special Procedures'. These are independent experts, including some known as Special Rapporteurs,[37] and Working Groups established to monitor and investigate specific human rights issues. Special Rapporteurs will have either a thematic mandate (e.g. the right to the highest attainable standard of health) or a country-specific mandate. They may carry out country visits with the consent of the relevant government, and may also receive individual complaints from, or on behalf of, victims of human rights abuses. Working Groups have exclusively thematic mandates. In carrying out their work the Special Procedures work closely with governments, victims and civil society. Although the Council has direct responsibility for the Special Procedures, they also make annual reports directly to the General Assembly.

Some of the thematic Special Rapporteurs and Working Groups are of particular importance for international drug control. These include the Special Rapporteurs on the Right to the Highest Attainable Standard of Physical and Mental Health, on Extrajudicial, Summary or Arbitrary Executions, on the Rights of Indigenous Peoples, and on Violence Against Women, as well as the Working Group on the Use of Mercenaries.[38] While the Human Rights Council is relatively new and has not yet addressed drug-related issues, in recent years a number of the Special Procedures have raised concerns about human rights and drug policy.[39]

UN Secretariat: OHCHR and UNODC

A third Principal Organ that must be noted in this context is the UN Secretariat, headed by the UN Secretary-General. Both the Office of the High Commissioner for Human Rights (OHCHR), based in Geneva, and the UN Office on Drugs and Crime (UNODC), based in Vienna, are full departments of the Secretariat.

Headed, currently, by Louise Arbour (UN High Commissioner for Human Rights) and Antonio Maria Costa (Executive Director of UNODC)[40], these bodies serve as secretariats for the human rights and drug control systems respectively, and carry out the substantive work of the relevant inter-state bodies (the Human Rights Council and the CND). Both have field offices around the world; promote

34 Legally speaking, the CND, like other UN political bodies, is a recommendation-making entity. In practice, however, it is instrumental in directing international drug policy

35 See further Part III below.

36 Under this procedure, all UN member states must report to the Council for a review of their human rights record guided by the Universal Declaration.

37 Some are known simply as Independent Experts, but none are referred to in this paper.

38 For the full list of thematic Special Procedures see http://www2.ohchr.org/english/bodies/chr/special/themes.htm (Date of last access: 7 February 2008).

39 The Special Rapporteur on the right to the highest attainable standard of physical and mental health, for example, has noted that harm reduction is fundamental to protect the right to health of injecting drug users and has also raised the health implications of illicit crop spraying on the Ecuador/Colombia border. The Special Rapporteur on violence against women has noted that women with drug problems in Sweden may not gain access to shelters if they face domestic violence and the Special Rapporteur on arbitrary executions has stated that the death penalty for drug offences violates international human rights law. The Working Group on the use of mercenaries has also raised human rights concerns around the use of private companies for crop eradication in Latin America. On specific human rights violations relating to drug control, See Part II below.

40 Both hold the rank of Under-Secretary General of the United Nations.

international co-operation in their respective fields; conduct capacity building and provide legal and technical support to national governments and agencies.

The UNODC's mission is to 'contribute to the achievement of security and justice for all by making the world safer from drugs, crime and terrorism.'[41] The OHCHR is mandated to 'promote and protect the enjoyment and full realization, by all people, of all rights established in the Charter of the United Nations and in international human rights laws and treaties'.[42] In addition, the OHCHR 'leads efforts to integrate a human rights approach within all work carried out by United Nations agencies'.[43] The work of both offices is therefore crucial if human rights are to be fully respected and protected in relation to international drug control.

The OHCHR and the UNODC rely on core funding from the UN as well as voluntary contributions from UN member states to carry out their work. Both have similar budgets, but in both cases voluntary contributions far outweigh core funding. In the case of the OHCHR, just over 30% of the approximate $248 million budget (around $83 million) comes from core costs.[44] For UNODC, this figure is closer to 12%, with around $33.1 million of its $283.1 million budget for 2006-2007 coming from UN regular budgets.[45] The result is that donor interests weigh heavily upon the operational focus and capacity of both offices.[46]

Treaty-based systems

Overview: International treaty obligations

All Members of the UN are bound by the Charter of the United Nations. However, there is no corresponding obligation on UN Members to ratify the various human rights and drug control conventions. Rather, each national government must, using its own domestic legislative process, choose whether or not to ratify a treaty before the terms of that treaty are binding on the state. Unless and until a government ratifies the treaty, it cannot be considered a party to that treaty. However, once this consent is provided, states have a legal obligation to uphold the protections and standards the treaty articulates.

International treaties are contracts between sovereign states. It is this contractual arrangement, and the good faith it requires on the part of countries that have ratified the treaty (known as 'states parties'), that largely provides the political weight to the international treaty system, particularly in the absence of direct enforcement mechanisms in the drug control and human rights treaties.[47] In ratifying the human rights and drug control conventions, states parties accept that these issues are in the international domain and not exclusively domestic issues. They therefore submit to international scrutiny and bind themselves to the same terms as the other states parties to the relevant conventions.

How individual states go about implementing certain broad requirements remains 'essentially within the domestic jurisdiction' of the state, an important principle of non-intervention in the Charter.[48] This jurisdictional line, however, is not always clear and has become an issue of considerable controversy in relation to domestic measures aimed at the implementation of the drug control treaties.[49]

41 'Strategy for the period 2008-2011 for the United Nations Office on Drugs and Crime' Note by the Secretariat, available at http://www.unodc.org/unodc/en/about-unodc/unodc-strategy.html.

42 See http://www.ohchr.org/EN/AboutUs/Pages/Mandate.aspx (Date of last access: 19 February 2008).

43 ibid.

44 Based on 2006-2007 figures. Estimated need for 2008-2009 will be $312 million. OHCHR, 'High Commissioner's Strategic Management Plan 2008-2009', http://www.ohchr.org/Documents/Press/SMP2008-2009.pdf, p. 108 (Date of last access: 18 February 2008).

45 'Outline of the consolidated budget for the biennium 2008-2009 for the United Nations Office on Drugs and Crime', UN Doc No E/CN.7/2007/12–E/CN.15/2007/15, 19 January 2007, p. 5, fig. A. Estimated figures for 2008-2009 are $326.1 million. ibid., p. 6 fig. B.

46 For a list of donors to each Office see OHCHR, 'Annual Report 2006', p. 158 http://www.ohchr.org/Documents/AboutUs/annualreport2006.pdf; and UNODC, 'Annual Report 2007', p. 89 http://www.unodc.org/pdf/annual_report_2007/keyfinancialdata.pdf (Date of last access: 18 February 2008).

47 This contractual good faith is often referred to as 'Pacta Sunt Servanda'. Art 26 of the Vienna Convention on the Law of Treaties (1969) states that 'Every treaty in force is binding upon the parties to it and must be performed by them in good faith.' Vienna Convention on the Law of Treaties, 1155 U.N.T.S. 331, 8 I.L.M. 679, *entered into force* Jan. 27, 1980, art 26.

48 The Charter of the United Nations, art 2(7), states that the UN shall not intervene in issues that are 'essentially within the domestic jurisdiction of any state'.

49 See, for example, 'Drug control undermining HIV prevention, treatment, care and support' in Part II below, notably the views of the International Narcotics Control Board on safe injecting facilities, which it claims violate the terms of the international drug conventions, despite the views of the UNDCP's own legal experts to the contrary. UNDCP Legal Affairs Section, 'Flexibility of treaty provisions as regards harm reduction approaches', E/INCB/2002/W.13/SS.5 (UNDCP Legal Affairs Section, September 2002) Available at: http://idpc.info/php-bin/documents/UN_HarmReduction_EN.pdf (Date of last access: 17 February, 2008). See also 'Room for Manoeuvre' (2000) and 'How Flexible are the Drug Conventions' (1999), op.cit.

The international human rights conventions

The treaty-based human rights system at the UN level is based on core international conventions, including the following:[50]

- International Covenant on Civil and Political Rights (ICCPR)[51]
- International Covenant on Economic, Social and Cultural Rights (ICESCR)[52]
- Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment (CAT)[53]
- Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW)[54]
- International Convention on the Elimination of All Forms of Racial Discrimination (ICERD)[55]
- Convention on the Rights of the Child (CRC)[56]
- International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families (CMW)[57]
- International Convention for the Protection of All Persons from Enforced Disappearance (not yet in force)[58]
- International Convention on the Protection and Promotion of the Rights and Dignity of Persons with Disabilities (not yet in force)[59]

Every person possesses human rights by virtue of their inherent dignity and humanity.[60] These rights are not conferred by states and they do not need to be earned by individuals. Rather than creating the rights they contain, the human rights treaties are seen as enumerating in further detail and making binding upon states parties the requirements of the principles contained in the *Universal Declaration of Human Rights*.[61] States parties to a treaty commit to respect, protect and fulfil the rights contained in the treaties and to be subject to international jurisdiction on those issues'[62]

All human rights are universal, indivisible and interdependent and interrelated.[63] Though separate, the human rights treaties are intended to be read as a body with the terms of each treaty informing the interpretation of the others. So, for example, gender discrimination is prohibited in all nine of the major treaties listed above. What is required to tackle such discrimination is further developed in *Convention on the Elimination of all forms of Discrimination against Women (CEDAW)*, which was developed specifically to deal with this issue. Some of the specific rights and freedoms contained in these core conventions will be dealt with in Part II.

Monitoring the human rights conventions

In addition to defining specific human rights protections, almost every treaty also establishes a committee of independent experts (known as a 'treaty body') to monitor the progress of states towards meeting the obligations enshrined in that treaty.[64] The UN Human Rights Committee, for example, monitors states' domestic implementation of the International Covenant on Civil and Political Rights, the Committee on the Rights of the Child monitors the implementation at country level of the Convention on the Rights of the Child, and so on. With the exception of the Committee on Economic Social and Cultural Rights, which reports to ECOSOC, each of the treaty bodies reports annually to the General Assembly.[65]

50 There are also dozens of non-binding guidelines and declarations as well as numerous related binding conventions. See http://www2.ohchr.org/english/law/index.htm#instruments (Date of last access: 17 December 2007).

51 International Covenant on Civil and Political Rights, G.A. res. 2200A (XXI), 21 U.N. GAOR Supp. (No. 16) at 52, U.N. Doc. A/6316 (1966), 999 U.N.T.S. 171, *entered into force* Mar. 23, 1976 (Hereafter ICCPR).

52 International Covenant on Economic, Social and Cultural Rights .A. res. 2200A (XXI), 21 U.N. GAOR Supp. (No. 16) at 49, U.N. Doc. A/6316 (1966), 993 U.N.T.S. 3, *entered into force* Jan. 3, 1976 (Hereafter ICESCR).

53 Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment G.A. res. 39/46, annex, 39 U.N. GAOR Supp. (No. 51) at 197, U.N. Doc. A/39/51 (1984), *entered into force* June 26, 1987. (Hereafter CAT).

54 Convention on the Elimination of All Forms of Discrimination Against Women G.A. res. 34/180, 34 U.N. GAOR Supp. (No. 46) at 193, U.N. Doc. A/34/46, *entered into force* Sept. 3, 1981. (Hereafter CEDAW).

55 International Convention on the Elimination of All Forms of Racial Discrimination 660 U.N.T.S. 195, *entered into force* Jan. 4, 1969. (Hereafter ICERD).

56 Convention on the Rights of the Child G.A. res. 44/25, annex, 44 U.N. GAOR Supp. (No. 49) at 167, U.N. Doc. A/44/49 (1989), *entered into force* Sept. 2, 1990 (Hereafter CRC).

57 International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families .A. res. 45/158, annex, 45 U.N. GAOR Supp. (No. 49A) at 262, U.N. Doc. A/45/49 (1990), *entered into force* July 1, 2003 (Hereafter CMW).

58 International Convention for the Protection of All Persons from Enforced Disappearance G.A. res A/RES/61/177 (2007).

59 International Convention on the Protection and Promotion of the Rights and Dignity of Persons with Disabilities G.A. res. A/61/611 (2006).

60 The preamble of the Universal Declaration of Human Rights notes that 'the inherent dignity and…the equal and inalienable rights of all members of the human family is the foundation of freedom, justice and peace in the world'. Art. 1 goes on to state that 'All human beings are born free and equal in dignity and rights'. The Charter of the United Nations also reaffirms the international community's 'faith in fundamental human rights, in the dignity and worth of the human person'.

61 The International Covenant on Civil and Political Rights and the International Covenant on Economic, Social and Cultural Rights were specifically drafted to make legally binding the UDHR. Together these three documents form the 'International Bill of Human Rights'.

62 The most ratified of the treaties under discussion is, without doubt, the UN Convention on the Rights of the Child. It has 193 States parties, exceeding even membership of the UN. Ironically, it is the only human rights treaty to specifically mention drugs. The ICCPR has 160; ICESCR, 157; CAT, 145; CEDAW, 185; CERD, 175; and CMW, 37. The Disabilities and Enforced Disappearances Conventions will enter into force once they have each received 20 ratifications.

63 Vienna Declaration and Programme of Action, World Conference on Human Rights, UN Doc A/CONF.157/23, 12 July 1993, para 5.

64 The Committee on Economic, Social and Cultural Rights, tasked with monitoring states' implementation of the International Covenant on Economic, Social and Cultural Rights, was created in 1985 by an ECOSOC resolution to carry out the monitoring functions assigned to ECOSOC by the Covenant. 'Review of the composition, organization and administrative arrangements of the Sessional Working Group of Governmental Experts on the Implementation of the International Covenant on Economic, Social and Cultural Rights' (28 May 1985) UN Doc. no. E/RES/1985/17.

65 Discussions are underway at the human Rights Council, however, to rectify the legal status of the Committee on Economic Social and Cultural Rights so that it too shall report to the General Assembly. See 'Report of the Office of the High Commissioner for Human Rights on the Rectification of the Legal Status of the Committee on Economic, Social and Cultural Rights', UN Doc. A/HRC/6/21, 7 November 2007.

The committees fulfil their mandate primarily through a 'periodic reporting' function, in which states parties to the given treaty must submit a report to that independent expert committee every three to five years (depending on the terms of the treaty) and have their human rights record under that treaty reviewed. It is important to note, however, that the underlying principle of the periodic reporting process is one of 'constructive dialogue' rather than criticism or confrontation. The purpose is primarily to create an ongoing discussion between the state, the committee and civil society on respect for, and observance of, human rights in the country, not to 'name and shame'.[66]

Following each of these periodic reviews,[67] the committee in question will issue a report, called its Concluding Observations, on the state's progress, noting areas of good implementation and also recommendations for improvement.[68] It will revisit previous Concluding Observations at each reporting process to assess whether improvements have been made.

The role of civil society is crucial in this process to ensure an open and full dialogue, and that all relevant information is available to the committee. Such engagement is actively encouraged and a number of the committees have issued guidelines to assist NGO involvement.[69] It is in the course of the periodic reporting procedure that some of the treaty bodies have raised human rights concerns relating specifically to drug control.[70]

The international drug control conventions

The treaty-based drug control system is very 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)[71] as amended by the 1972 Protocol[72]
- The Convention on Psychotropic Substances (1971)[73]
- The Convention Against the Illicit Traffic in Narcotic Drugs and Psychotropic Substances (1988)[74]

The 1961 Single Convention was intended to codify most of the numerous international drug conventions dating back to 1912, and places under international control primarily plant-based substances such as coca, marijuana and opium, as well as their derivatives. Acknowledging the need for medicinal opiates, states parties must submit estimates to an independent committee (the International Narcotics Control Board) of their opiate needs for the coming year. A 'statistical returns system' is also created in the 1961 Single Convention to assess state implementation of its terms. It includes information relating to the production of drugs, drug consumption and imports/exports of controlled substances.[75] The 1972 Protocol to the 1961 Single Convention expands the role of the International Narcotics Control Board in relation to the illicit production, use and traffic in narcotic drugs.

A reading of the preamble to the 1961 Single Convention reveals the moralistic justifications that form the basis of international drug control and predominate in national policies. It declares that 'addiction to narcotic drugs constitutes a serious evil for the individual and is fraught with social and economic danger to mankind', and notes the duty of states parties to 'combat this evil'.[76]

The 1971 Convention extends international control to cover synthetic psychotropic substances, such as LSD and MDMA, as well as their precursor chemicals. There is no system of estimates in the 1971 Convention, but it does retain a statistical returns system similar to that of the 1961 Single Convention.[77] Its control system is therefore considerably weaker than that of the 1961 Single Convention. This is due in large part to the strong pharmaceutical lobby keen to draw

66 In addition, each committee is mandated to interpret the terms of treaty for which it is responsible in order to provide guidance to states in fulfilling their treaty obligations. These are typically done in the form of General Comments, in essence detailed commentaries on how the committee interprets the scope of the right or treaty article in question. Some of the committees, most notably the Human Rights Committee, are also empowered to consider individual complaints or 'communications' from persons who allege to have suffered human rights violations. Some may hear 'inter-state communications', but this mechanism has never been used.

67 For more information on the periodic reporting process see Office of the High Commissioner for Human Rights, 'Fact Sheet No. 30, the UN Human Rights Treaty System', pp. 15-25, http://www.ohchr.org/Documents/Publications/FactSheet30en.pdf (Date of last access: 14 February 2008).

68 As human rights treaties are considered to be interrelated, a treaty body may refer to recommendations made by other treaty bodies when considering state reports. They will also recommend ratification of any human rights (and related) treaties to which the reporting state is not yet a party.

69 See Committee on Economic Social and Cultural Rights UN Doc. no. E/C.12/2000/6; and Committee on the Rights of the Child UN Doc. no., CRC/C/90, annex VII.

70 The Committee on the Rights of the Child has raised concerns about the right to health of children and young people affected by crop spraying in Colombia and the Committee on Economic Social and Cultural Rights has called for harm reduction measures such as needle and syringe exchange and opioid substitution treatment for people who use drugs as a component of the right to health. The Human Rights Committee has noted that the death penalty for drug offences is a violation of the right to life. For more detail, see Part II below.

71 Single Convention on Narcotic Drugs, 1961, March 30, 1961, 520 U.N.T.S. 204 (Hereafter 1961 Single Convention).

72 Protocol Amending the Single Convention on Narcotic Drugs, 25 March 1972, TIAS No 8118, 976 UNTS 3 (Hereafter 1972 Protocol).

73 Convention on Psychotropic Substances, 1971 32 U.S.T. 543, T.I.A.S. 9725, 1019 U.N.T.S. 175 (Hereafter 1971 Convention).

74 1988 Convention op.cit.

75 1961 Single Convention, arts 13 & 20.

76 ibid., preamble.

77 1971 Convention, art. 13(4).

a balance between, on the one hand, using controls to protect the interests of established producers from new competitors, and on the other, continuing to expand production and worldwide marketing by ensuring that such controls did not go too far.[78]

The 1988 Convention, arguably the most prescriptive and punitive of the three, is focused on the illicit traffic of the substances under control in the 1961 and 1971 Conventions. Its primary aims are increased international law enforcement and stronger domestic criminal legislation.[79]

Each treaty encourages, and in some instances requires, criminal sanctions to be put in place at the national level.[80] That said, many states have adopted interpretations of those sections that refer to criminal sanctions that have resulted in measures that are well beyond the requirements of the conventions.[81] Nonetheless, the international drug 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. Expenditure by the UNODC reflects this imbalance, as does the work of the INCB.

Monitoring the drug 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) was created by the 1961 Single Convention and is mandated to oversee implementation of all three of the drug conventions.[82]

The INCB is made up of thirteen members acting in their personal capacities. It 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.[83] Unfortunately, the work of the INCB has been disproportionately in favour of the former, 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 has publicly stated that it will not engage with civil society[84] and, as noted above, that it will not discuss human rights.[85]

Unlike the human rights treaties, the 1961 and 1971 drug conventions also assign treaty obligations to the relevant inter-state body, the Commission on Narcotic Drugs. The CND has responsibility for the inclusion or removal of narcotic drugs and psychotropic substances from the schedules of control (although CND decisions must be approved by ECOSOC in this regard).

As will be explored in Part II, this power is of particular importance from a human rights perspective. Methadone, for example, is a 'schedule 1' substance under the 1961 Single Convention, meaning that access should be strictly limited. Yet methadone is considered an essential medicine by the World Health Organization, and is recognised to be an important tool in HIV prevention and the reduction of other drug related harms. The coca leaf is also scheduled under the 1961 Single Convention yet has long been the focus of discussion and legal ambiguity. Coca is subject to massive eradication projects in Latin America, despite the reliance of local farmers on its production for their livelihoods, and despite the fact that coca is not dangerous per se and has been used for cultural purposes by indigenous peoples in Andean regions for centuries.[86]

78 William B McAllister, *Drug Diplomacy in the Twentieth Century: An International History*, Routledge, New York, 2000, pp. 229 & 230 (Hereafter Drug diplomacy in the twentieth century).

79 Each of the drug conventions has 183 states parties.

80 See, in particular, art 3(2), 1988 Convention.

81 The Canadian HIV/AIDS Legal Network has, for example, noted an important misinterpretation of art 3(2) of the 1988 convention. According to the Legal Network, art 3(2) 'has often been incorrectly interpreted as requiring the full criminalization of any possession of a prohibited drug. Article 3(2) says that each state party to the Convention must make it a criminal offence under its domestic law to intentionally 'possess, purchase or cultivate narcotic drugs or psychotropic substances for personal consumption contrary to the provisions of the 1961 Convention, the 1961 Convention as amended or the 1971 Convention.' However, the obligation to impose criminal sanctions goes no further than the equivalent obligations in the 1961 and 1971 Conventions. The 1988 Convention only requires signatory states to criminalize possession for personal consumption that is 'contrary to the provisions' of the 1961 and 1971 Conventions. Thus, the flexibility found in the two earlier conventions is preserved. As noted above, those Conventions include a number of provisions that make it legally permissible to remove, at least to some degree, the criminalization of people who use or possess drugs — if, for example, decriminalization is in pursuit of 'medical or scientific purposes' or forms part of practicable measures to provide care, treatment or support to people who use drugs. It is incorrect to interpret the 1988 Convention as requiring the complete criminalization, without exception, of possession of a drug for the purposes of personal consumption'. Canadian HIV/AIDS Legal Network, 'Legislating for Health and Human Rights: Model Law on Drug Use and HIV/AIDS, Module 1, Criminal Law Issues', 2006, pp. 11-12, online via www.aidslaw.ca/drugpolicy (Date of last access: 19 February 2008).

82 The Board has predecessors dating back to the League of Nations, but the INCB in its current incarnation derives its mandate from the three international drug conventions.

83 See in particular ICESCR, art. 12, CEDAW art. 12, CERD, art. 5(e)(iv) and CRC, art 24.

84 Dr Philip Emafo, President of the INCB, March 2007 op.cit.

85 Mr Koli Kouame, Secretary of the INCB, March 2007, op.cit.

86 'Coca yes, cocaine, no? Legal Options for the coca leaf", TNI Drugs and Conflict Debate Papers, May 2006 and *Antonil, Mama Coca*, Hassle Free Press, 1978.

Conflicts and hierarchies in the UN system

Thus far, this paper has described the structures and legal foundations of the human rights and drug control systems within the UN. What happens, however, if the requirements of one system run contrary to those of the other? Which system, human rights or drug control, should take precedence?

Conflicting ideologies

Like their predecessors, the three UN drug control conventions were established by the international community with the objective of preventing the non-scientific and non-medical production, supply and use of narcotic and psychotropic drugs. Indeed, 'while the substance of the drug control conventions is complex, their function is simple. They provide the legal structure for an international system of drug control by defining control measures to be maintained within each state party to these conventions and by prescribing rules to be obeyed by these Parties in their relations with each other'[87]. As Neil Boister notes, these rules can be categorised by two principal methods of achieving drug control. These are commodity control (the definition and regulation of the licit production, supply and consumption of drugs) and penal control (the suppression through criminal law of illicit production, supply and possession).[88] The conventions operate with the intention of creating an appropriate balance between possible penal sanctions, the degree of real and/or potential harm associated with specific drugs, and their therapeutic usefulness.

Thus, the international 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.

The preambles to the 1961 and 1971 Conventions note the overarching concern of states parties for the 'health and welfare of mankind.' But 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. In the debates and discussions leading up to the 1961 Single Convention, the needs of individual people who use drugs were rarely discussed. As the historian William McAllister comments, ''the problems of addicts and addiction often did not feature prominently in international deliberations'.[89] Debates, instead, focused largely on economic protectionism and prohibitionist ideology, driven by a handful of powerful western states.[90]

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. It is worth reiterating that these principles all find their basis in the *Charter of the United Nations* and the *Universal Declaration of Human Rights*.

The first is the **principle of non-discrimination**. This principle is found in all of the human rights treaties,[91] and places upon states parties to those treaties two separate, but related, obligations. The first of these is the 'negative obligation' to avoid discriminating against certain individuals and groups on a variety of explicitly enumerated grounds (e.g., race, colour, sex, religion, etc.), or on the basis of 'other status'.[92] which has been interpreted as including health status (including HIV status).[93] The second aspect is the 'positive obligation' to actively identify those individuals and groups in need of special measures and to take measures to in order to diminish or eliminate conditions that cause discrimination.[94] Despite these negative and positive obligations, examples of disproportionate application of criminal measures concerning drugs against indigenous peoples, ethno-racial minorities, and those living in poverty, are all too common. Similarly, the implementation of drugs policies 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.

87 Neil Boister, *Penal Aspects of the Un Drug Conventions*, Kluwer Law International, 2001, p. 2.

88 ibid., pp.1-4. While Boister (p. 2) talks of penal controls suppressing, through criminal law, the consumption of illicit drugs, the Conventions actually explicitly regulate and penalise possession rather than consumption. See arts 33 and 36 of the Single Convention, arts 5 and 22 of the 1971 Convention and art 3 of the 1988 Convention. That said, it is clear that commodity and penal controls are undoubtedly ultimately intended to prevent/deter the consumption of drugs on the basis that consumption is impossible without possession.

89 'Drug Diplomacy in the Twentieth Century' , p. 5.

90 For an historical account of the process leading up to the 1961 Single Convention, see ibid., ch. 7. See also chapters 8 & 9 which cover the 1971 and 1988 conventions.

91 The CERD and CEDAW are directed specifically at racial and gender discrimination, but see also art 2 CRC, art 2(1) ICCPR and art. 2(2) ICESCR, op.cit.

92 Art 2(2) of the ICESCR, for example, states that 'The States Parties to the present Covenant undertake to guarantee that the rights enunciated in the present Covenant will be exercised without discrimination of any kind as to race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or **other status**' [Emphasis added].

93 See for example, 'The protection of human rights in the context of human immune deficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS)', UN Commission on Human Rights, Resolution 1999/49 and subsequent resolutions to this effect; Committee on Economic, Social and Cultural Rights, *General Comment 14: The Right to the Highest Attainable Standard of Health*, UN Doc. E/C.12/2000/4, 11 August 2000, para 18; and Committee on Economic Social and Cultural Rights, 'General Comment No. 19, The Right to Social Security', UN Doc no E/C.12/GC/19, 30 January 2008, para 29.

94 See Human Rights Committee, general comment No. 18 (1989), HRI/GEN/1/Rev.6; Committee on the Rights of the Child, 'General Comment No. 5, General Measures of Implementation', UN Doc CRC/GC/2003/5, 27 November 2003, p. 4; and Committee on Economic Social and Cultural Rights, General Comment No 19, ibid., para 31.

Non-discrimination is closely connected with the second underlying principle, that of **protecting the most vulnerable**. Indeed, this principle permeates the entire human rights treaty system, with five of the nine treaties listed above specifically intended to provide greater protection to vulnerable groups (women, children, persons with disabilities, racial minorities and migrant workers). However, individuals who use drugs — often some of the most marginalised in the community — are criminalised and stigmatised in the international drug control system. Furthermore, local farming communities in developing countries face the brunt of supply-side control efforts, while the international drug conventions are silent on socio-economic root causes of problematic drug use among the most at-risk communities. 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 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, in practice, been a priority, and have instead been overshadowed, and often badly damaged, by the pursuit of that drug-free ideal.

A third principle is that of **empowerment**. This principle runs throughout the human rights treaties, and is reflected in such matters as the right to self-determination of peoples, to the rights to freedom of expression, religion, privacy and association, the right to political participation, the right of the child to be heard, the right to vote, and the right to engage in cultural activities. The international drug conventions, on the other hand, 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).

Closely connected to this third principle is the essential need to involve civil society in governance, and to consult with and listen to affected communities in the policies that affect them. As noted by UNODC, 'a community-wide participatory and partnership approach is crucial to the accurate assessment of complex problems'.[95] Given the impact of drug control on human rights, lack of civil society engagement in this area of global policy raises significant human rights concerns. It is certainly understood in almost every other UN arena that civil society engagement, and the involvement of affected communities, are essential if human rights violations and progress on issues such as HIV prevention and drug use are to be addressed.[96] 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.[97]

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, yet is 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.

Conflict of laws: Primacy of the UN Charter

The issue of conflicts between international legal systems can be extremely technical and complicated.[98] There are, however, some recognised legal hierarchies. One of these is of particular relevance in the present context — the primacy of the Charter of the United Nations.[99]

Art 103 of the Charter states that:

In the event of a conflict between the obligations of the Members of the United Nations under the present Charter and their obligations under any other international agreement, their obligations under the present Charter shall prevail.

Both the human rights treaties and the drug control conventions are 'other international agreements', and on this basis hold an identical status in law as individual treaties. As bodies of law geared towards achieving the purposes in the Charter, however, the situation is very different.

Protection of human rights is clearly and specifically stated as a purpose of the UN in the Charter, and as a specific legal obligation of all UN member states— not surprisingly, given the creation of the UN in the aftermath of the horrors of two World Wars. Indeed, the protection of human rights is mentioned seven times in the Charter, from the preamble,[100] to the purposes of the UN,[101] to the responsibilities of the General Assembly[102] and the Economic and

95 NGO Liaison Service, *UN System Engagement with NGOs, Civil Society, the Private Sector and Other Actors: A Compendium* (2005), p. 181.

96 One of the most important formulations of this principle is 'The Greater Involvement of People Living With HIV (GIPA)', adopted by UNAIDS http://data.unaids.org/pub/BriefingNote/2007/JC1299_Policy_Brief_GIPA.pdf (Date of last access: 7 February 2008). See also 'Nothing About Us Without Us: Greater, Meaningful Involvement of People Who Use Illegal Drugs; A Public Health, Ethical, and Human Rights Imperative', Canadian HV/AIDS Legal Network, 2005.

97 See the comments of Dr Philip Emafo at the March 2007 press conference to present the INCB's 2007 annual report, op.cit.

98 For a summary of many of the issue see 'Fragmentation of International Law', op.cit.

99 ibid., paras. 34-36.

100 The Preamble of the Charter notes the determination of the United Nations to 'to reaffirm faith in fundamental human rights' and in 'the dignity and worth of the human person'.

101 ibid., arts 1 & 55.

102 ibid., art 13(1)(b).

Social Council[103] (the organs which also have responsibility for drug control and the CND). In 1948, the *Universal Declaration of Human Rights* was adopted to 'give expression' to the content of the human rights obligations contained in the Charter.[104]

Tackling the global drug trade, on the other hand, is not identified in the Charter as a purpose of the UN. This omission is instructive given that the earlier Covenant of the League of Nations specifically mentioned drug control.[105] *The Charter of the United Nations*, however, excludes all mention of drugs. This was no oversight. Instead, the delegates at the 1945 San Francisco Conference that drafted the UN Charter made it clear that drug control came within the definition of 'international economic, social, health and related problems' contained in Article 55.[106]

Drug control was therefore seen from the outset as a subset of the higher purposes of the UN, while human rights were one of the key purposes and principles. This position has been recently reinforced in the UN system by the creation of the new Human Rights Council, which, according to then Secretary-General Kofi Annan, was created to afford human rights 'a more authoritative position, corresponding to the primacy of human rights in the *Charter of the United Nations*'.[107]

Indeed, human rights, along with peace and security and development, are considered one of the three pillars of the UN. Each pillar now has a specific council to reflect the importance of these aims. The Human Rights Council now sits alongside the Economic and Social Council (development) and the Security Council (peace and security), both of which are also elected by the General Assembly, a considerable promotion for human rights policy in the UN from the previous Commission on Human Rights.[108]

The political consensus also supports this position. In 1993, over 170 states adopted the Vienna Declaration and Programme of Action and affirmed that, 'Human rights and fundamental freedoms are the birthright of all human beings; their protection and promotion is the first responsibility of Governments'.[109]

Human rights, drug control and UN governance

The scope of Article 103 relating to the primacy of the Charter over other international agreements also extends to decisions of the Principal Organs of the United Nations.[110] In other words, it extends to the governance systems and hierarchies created by the Charter. This is a crucial point and serves to clarify further the primacy of human rights over drug control. The CND is a functional commission of ECOSOC, which in turn operates under the policy guidance of the General Assembly. However, the final authority for human rights and drug control rests with the General Assembly, under the terms of the Charter.

Every year, the General Assembly adopts a resolution entitled *International co-operation against the world drug problem*. Each resolution states that drug control activities must be in conformity with the 'purposes and principles' of the Charter of the UN.[111] (In this regard, these resolutions mirror those in relation to the protection of human rights while countering terrorism.[112]) In recent years, the General Assembly has gone further and 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.**[113] [Emphasis added]

It would be difficult to find a more definitive statement from the General Assembly as to which legal system takes precedence. Its resolutions clearly place drug control in a secondary position—reflecting, correctly, the aims of the Charter.

103 ibid., art 61(2).

104 'Explanatory Note by the Secretary-General on the Human Rights Council', para 7, op.cit.

105 Art 23(c), Covenant of the League of Nations, Treaty of Versailles, 1919, available at http://www.yale.edu/lawweb/avalon/imt/parti.htm (Date of last access: 20 February 2008).

106 Fifth report of the Drafting Committee 11/3 of the San Francisco Conference, document WD 40 11/3/A/5, 25 May 1945; statements of the representatives of Canada, China, India and the United States in Committee 11/3, verbatim minutes of 19th meeting, 4 June 1945. See also Commentary on the Single Convention on Narcotic Drugs, 1961, art 5, Commentary 1.

107 'In Larger Freedom: towards development, security and human rights for all, report of the Secretary-General', UN Doc. A/59/2005 para. 183 (Hereafter In Larger Freedom).

108 The Human Rights Council is not legally equal to ECOSOC and the Security Council. It was, in fact, under consideration to establish the Council as a new Principal Organ of the United Nations so that it was equal in status to the other Councils, but this would have required an amendment to the Charter. See 'Explanatory Note by the Secretary-General on the Human Rights Council',, para 14, op.cit.

109 'Vienna Declaration and Programme of Action' para 1, op.cit.

110 'Fragmentation of International Law' para 35, op.cit.

111 UNGA Res 61/183 (13 March 2007) UN Doc A/RES/61/183.; UNGA Res 60/178 (22 March 2006) UN Doc A/RES/60/178.; See also UNGA Res 46/101 (16 December 1991) UN Doc A/RES/46/101.; UNGA Res 47/98 (16 December 1992) UN Doc A/RES/47/98.; UNGA Res 48/112 (11 March 1994) UN Doc A/RES/48/112.; UNGA Res 49/168 (24 February 1995) UN Doc A/RES/49/168.; UNGA Res 50/148 (9 February 1996) UN Doc A/RES/50/148.; UNGA Res 51/64 (28 January 1997) UN Doc A/RES/51/64.; UNGA Res 53/115 (1 February 1999) UN Doc A/RES/53/115.; UNGA Res 54/132 (7 February 2000) UN Doc A/RES/54/132.; UNGA Res 55/65 (26 January 2001) UN Doc A/RES/55/65.; UNGA Res 56/124 (24 January 2002) UN Doc A/RES/56/124.; UNGA Res 58/141 (10 February 2003) UN Doc A/RES/58/141.; UNGA Res 59/153 (8 February 2005) UN Doc A/RES/59/153

112 See for example UNGA Res 61/171 UN Doc A/RES/61/171 1 March 2007, in which the General Assembly called on all states to 'ensure that any measure taken to combat terrorism complies with their obligations under international law, in particular international human rights, refugee and humanitarian law'.

113 UNGA Res 61/183 (13 March 2007) UN Doc A/RES/61/183 para 1; See also, for example, the previous year's resolution UNGA Res 60/178 (22 March 2006) UN Doc A/RES/60/178 para 1.

It is clear that human rights have a higher standing in the Charter and therefore in the UN system.[114] If there is a conflict between drug control and the human rights obligations in the Charter and the *Universal Declaration of Human Rights*,[115] the protection of human rights must be the priority. 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. Yet the CND has never referred in a resolution to the human rights requirement of the General Assembly's repeated resolutions, which clearly requires action on its part. It has referred to the *Universal Declaration of Human Rights* on only a small number of occasions in preambular paragraphs to resolutions dealing with HIV.[116] It has never required any operational action by the UNODC on the human rights aspects of drug control and law enforcement, despite the obvious and serious implications of this work.

This failure to take action on human rights is due in large part to the singular focus on operating by consensus at the CND, an approach that has been heavily criticised by former UN Secretary-General Kofi Annan. Referring in 2005 to increased use of consensus-based resolutions at the General Assembly, Annan stated that, 'consensus (often interpreted as requiring unanimity) has become an end in itself…This has not proved an effective way of reconciling the interests of member states'. Rather, he said, it prompts a 'retreat into generalities, abandoning any serious effort to take action. Such real debates as there are tend to focus on process rather than substance and many so-called decisions simply reflect the lowest common denominator of widely different opinions'.[117]

Mr Annan's criticisms, made during his final term of office in the context of strengthening UN system coherence and promoting fundamental human rights across the UN, may easily be directed at the CND. Despite ECOSOC rules of procedure for its Functional Commissions stating clearly that 'decisions of the commission shall be made by a majority of the members present and voting',[118] the only issue voted on by CND is the scheduling of substances for control. This is primarily because this is specifically set out in the drug conventions.[119] No other issues, no matter how important, such as HIV prevention or human rights, are put forward for a vote.[120]

Unfortunately, there is broad support for the consensus approach at CND, with member states being nervous about divergent views on drug policy and fearing a vote against their respective positions. At best, however, this approach at the CND results in the stagnant debate and ineffective 'lowest common denominator' resolutions against which the former Secretary-General has cautioned. At worst, it allows certain states to effectively veto directives from superior bodies in the UN. The paucity of human rights considerations at the CND may well be an example of this. At the 48th CND session, for example, a Brazilian proposal to discuss a resolution entitled 'HIV/AIDS and the right to health', which made open reference to article 25 of the *Universal Declaration of Human Rights* in the context of HIV/AIDS, had to be withdrawn due to U.S. objections. The U.S. delegation claimed to have 'fundamental problems with the language' of the resolution.[121] Rather than call a vote, Brazil was forced to formally withdraw the resolution.

If drug policy must be carried out in conformity with human rights, as specifically required by the Charter and confirmed by the General Assembly,[122] then 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 to avoid complicity in human rights abuses and in order to influence domestic implementation of the international drug control conventions in line with human rights norms.[123] 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 concerns 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.

114 See E. Stettinius Jr, 'Human Rights in the United Nations Charter', *Annals of the American Academy of Political and Social Science*, Vol. 243, Essential Human Rights. (Jan., 1946), pp. 1-3.

115 'Explanatory Note by the Secretary-General on the Human Rights Council,', para 7, op.cit.

116 See CND resolutions 47/2 'Prevention of HIV/AIDS among drug users'; CND resolution 48/12 'Expanding the capacity of communities to provide information, treatment, health care and social services to people living with HIV/AIDS and other blood-borne diseases in the context of drug abuse and strengthening monitoring, evaluation and reporting systems'; and CND resolution 49/4 'Responding to the prevalence of HIV/AIDS and other blood-borne diseases among drug users'.

117 'In Larger Freedom', para 159. op.cit. Here, former Secretary General Kofi-Annan was warning of the dangers of the General Assembly's increasing use of consensus-based resolutions. The General Assembly operates, officially, on the basis of majority voting. Indeed, in 2007 a global moratorium on the death penalty was narrowly voted through by two-thirds of the Assembly, illustrating the benefit and effectiveness of a democratic approach. UNGA Res 62/149, 19 December 2007, UN Doc no A/RES/62/149. Adopted by 104 votes to 54, with 29 abstentions.

118 Rule 58.1, 'Rules of Procedure of the Functional Commissions of the Economic and Social Council', available at http://www2.ohchr.org/english/bodies/hrcouncil/docs/ECOSOC.rules_En.pdf (Date of last access: 12 February 2008).

119 See, for example, 1971 Convention art. 17(2).

120 The CND's working methods may be contrasted with other functional commissions of ECOSOC. For example, the Commission on the Status of Women (CSW) where recourse to a vote is more readily availed of, though consensus is still pursued as the political ideal. See, for example, the 48th session of the CSW in 2004 in which the US called for a vote on both the situation of women in the occupied Palestinian territories and on the taking of hostages. The issue related to a preambular paragraph reaffirming the Beijing Platform for Action http://www.un.org/News/Press/docs/2004/wom1446.doc.htm (Date of last access: 11 February 2008).

121 Transnational Institute, 'Policy Brief No. 13, The United Nations and Harm Reduction Revisited, and Unofficial account of the outcomes of the 48th CND session' April 2005 http://www.tni.org/policybriefings/brief13.pdf (Date of last access: 9 January 2008).

122 Ironically, the resolutions on drug control at the General Assembly are routinely adopted without a vote.

123 See further below, Part III.

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, exceeding ratification of most of the human rights conventions,[124] and it has been noted that 'whether or not they are a cause or a convenient excuse, the UN drug conventions are used by national governments to justify highly punitive legal measures and failure to implement services for IDUs'.[125]

The consequences of prioritising the criminalisation of drugs and people who use them over protecting and promoting health comes into stark focus in the context of the global HIV pandemic.[126] Two of the drug conventions predate the HIV epidemic and, as interpreted and implemented by many states, stand as significant barriers to HIV prevention efforts among injecting drug users. For example, Russia is suffering an explosive HIV epidemic driven to a significant degree by unsafe injecting drug use. Yet methadone maintenance treatment is illegal, despite its proven effectiveness as a critical element of HIV prevention because it allows opioid users to substitute a substance consumed orally for drugs otherwise used by injection, often with unsterile needles. This prohibition of a well-accepted medical treatment for opioid dependence is a clear result of the restrictive scheduling of methadone under the 1961 Single Convention. Indeed, despite the obvious negative public health and human rights impact of erecting such barriers to HIV prevention through unnecessarily restrictive interpretation and application of the UN drug conventions, 'national policies in countries with established injection-driven [HIV] epidemics… generally reveal remarkable consistency with the law-and-order emphasis of UN drug control'.[127]

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'. Yet despite this damaging impact 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 complicity in those violations. As noted by the Office of the High Commissioner for Human Rights (OHCHR), an organisation may be complicit in violations of human rights if it 'tolerates, or knowingly ignores' those abuses.[128] While individual member states must be held to account for their national policies and human rights abuses, it is also vital that human rights violations stemming from international 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.

124 This, however, does not in any way detract from the primacy of the Charter and the human rights obligations it contains, given expression in the Universal Declaration. See above, Part I.

125 Daniel Wolfe 'Alchemies of Inequality: Alchemies of Inequality' p. 171, op. cit.

126 See Elliott et al 'Harm Reduction, HIV/AIDS, and the Human Rights Challenge to Global Drug Control Policy' op.cit.

127 'Alchemies of Inequality' p. 173, op.cit.

128 Office of the United Nations High Commissioner for Human Rights 'The Global Compact and Human Rights: Understanding the Sphere of Influence and Complicity' (December 2004), p. 6. http://www.unglobalcompact.org/Issues/human_rights/gc_and_human_rights.pdf (Date of last access: 12 February 2008.

129 'Most of those killed in war on drug not involved in drug,' The Nation, November 27, 2007 (online at http://nationmultimedia.com/breakingnews/read.php?newsid=30057578). In August 2007, the military-installed government of General Surayud Chalanont appointed a special committee to investigate the extrajudicial killings during the 2003 war on drugs. The committee's report – which has never been made public – said that of 2,819 people killed between February and April 2003, more than 1400 were unrelated to drug dealing or had no apparent reason for their killings. Human Rights Watch, 'Thailand: Prosecute Anti-Drugs Police Identified in Abuses,' February 7, 2008 (online at http://hrw.org/english/docs/2008/02/07/thaila17993.htm); 'Southeast Asia: Most Killed in Thailand's 2003 Drug War Not Involved With Drugs, Panel Finds', Drug War Chronicle, Issue 512, March 2007, http://stopthedrugwar.org/chronicle/512/thailand_drug_killings_half_not_involved_panel_finds (Date of last access: 20 February 2008).

130 J Csete & D Wolfe 'Closed to Reason: The International Narcotics Control Board and HIV/AIDS' (2007) Open Society Institute & Canadian HIV/AIDS Legal Network, pp. 14 & 15 (Hereafter Closed to Reason).

131 ibid., p. 15.

132 Thai AIDS Treatment Action Group, Press Release, 14 February 2008, http://www.actions-traitements.org/spip.php?breve4227 (Date of last access: 20 February 2008).

133 Amnesty International 'Brazil', http://www.amnesty.org/en/region/americas/south-america/brazil (Date of last access: 13 February 2008).

134 Quoted in 'Blood on the streets as drug gang and police fight for control of Rio favelas', *Guardian*, 29 June, 2007 http://www.guardian.co.uk/world/2007/jun/29/brazil.international (Date of last access: 20 February 2008).

135 See ibid. and 'War on Rio's Drug Gang Slums', BBC News, 28 June 2007, http://news.bbc.co.uk/1/hi/world/americas/6251828.stm (Date of last access: 13 February 2008).

136 Luke Dowdney, 'Children of the Drug Trade: a case study of children in organised armed violence in Rio de Janeiro', *7 Letras*, 2003, p. 167 (Hereafter Children of the Drug Trade).

137 ibid., 168.

BOX I: Violence and Summary Execution

i. Thailand's 'War on Drugs'

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, the arbitrary arrest or blacklisting of several thousand more, intimidation of human rights defenders, and coerced or mandatory drug treatment. In its 2005 report on Thailand, the UN Human Rights Committee expressed concern over 'the extraordinarily large number of killings during the 'war on drugs' which began in February 2003,' and government failure adequately to investigate these killings, or prosecute and punish the alleged perpetrators. In November 2007, the Thai Office of the Narcotics Control Board (the coordinating and policy-making bureau for drug control efforts) disclosed that some 1,400 people killed and labelled as drug suspects during the war had no link to drugs at all.[129] The government has yet to fully investigate the killings or institute proceedings against the perpetrators.

While UNODC Executive Director, Antonio Maria Costa, sent a letter of concern to the Thai government about the killings, the INCB's subsequent visit to Thailand in 2004 resulted in no more than an expression of appreciation of police investigations into the killings. The INCB made no mention of the lack of investigation of government officials, and publicly congratulated the Thai government on the reduction of methamphetamine use with no mention of the measures adopted to achieve that reduction.[130] As noted by the Canadian HIV/AIDS Legal Network, '[i]n the face of an abusive drug crackdown that undermined humane drug treatment and HIV prevention, the Board could not muster a statement about protection of the human rights of drug users'.[131] In February 2008, Thailand's Interior Minister, Chalerm Yubamrung, publicly reinstated a war on drugs, prompting fears among human rights activists that the excesses of 2003 may be repeated.[132]

ii. Brazil – A War on Drugs in the Streets

In **Brazil**, police are engaged in an increasingly violent and frequently lethal war on drugs. Large scale operations in the country's *favelas* (shanty towns) have resulted in bloody armed battles with drug gangs. According to Amnesty International's 2007 report, for example, 'The state authorities in Rio de Janeiro adopted increasingly militarized tactics in their attempts to combat drug gangs which held sway over most of the city's shanty towns. An armoured troop carrier, colloquially called the 'caveirão', was used to police the poorest parts of the city. There were reports of bystanders being killed by military police officers shooting indiscriminately from 'caveirões'.[133]

Despite the high concentration of people in the favelas, armed police have engaged in open gunfire with drug gangs in an effort to stem the traffic in drugs and arms. The safety and welfare of residents appears to be a secondary concern. In 2007, Rio's security secretary, Jose Mariano Beltrame, said such conflicts were a 'bitter pill' that slum residents would have to swallow if they wished to rid their communities of the drug gangs.[134] Many victims of such gun battles have had no connection whatsoever to drugs. In one particularly violent confrontation in June 2007, between 19 and 24 people were killed in a single day, as part of a larger operation involving over 1300 police that laid siege to Complexo do Alemao in Rio, a complex of favelas that houses over 200,000 people. In the first half of 2007, official police figures recorded 449 killings in such confrontations, with another sixty police officers losing their lives.[135]

Children recruited into drug trafficking gangs are considered legitimate targets for armed police and are shot at without hesitation, a fact admitted and defended by police.[136] In 2001, fifty-two children and adolescents were officially recorded as having been killed in police operations against drug factions. This marked a significant rise in figures collected since 1993.[137] Extrajudicial executions carried out by police in Brazil have been well documented, with young, poor, black boys forming the majority of victims. In many cases, victims have been shot in the head at point blank range or shot in the back.[138] There is almost total impunity for police in such cases. Deaths are recorded not as murder or unlawful killing, but as self-defence, or as 'resistance followed by death'.[139]

138 ANCED and Forum DCA, 'Report of Civil Society on the Rights of the Child and the Adolescent in Brazil, Alternative Report Submitted to the Committee on the Rights of the Child', 2004, p. 76. (On file with the authors).

139 Amnesty International, 'Brazil', op.cit.

140 Basic Principles on the Use of Force and Firearms by Law Enforcement Officials (the Basic Principles), adopted by the Eighth United Nations Congress on the Prevention of Crime and the Treatment of Offenders, Havana, 27 August to 7 September 1990, U.N. Doc. A/CONF.144/28/Rev.1 para 112 (1990), http://www.unhcr.ch/html/menue3/b/h_comp43.htm (Date of last access: February 25, 2008), principle 4; United Nations Code of Conduct for Law Enforcement Officials, adopted December 17, 1979, G.A. res. 34/169, annex, 34 U.N. GAOR Supp. (No. 46) para. 186, U.N. Doc. A/34/46 (1979), http://www.unhcr.ch/html/menu3/b/h_comp42.htm (Date of last access: February 25, 2008), art 3.

141 Basic Principles, principle 5.

But condemnation of abuses is not enough. There has been a conspicuous lack of policy guidance from the UN on human rights compliant drug policies in the implementation of the international drug conventions. Such top-down policy guidance 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

International law enforcement standards set strict limits on the use of lethal force in police operations. The UN Basic Principles on the Use of Force and Firearms by Law Enforcement Officials and the Code of Conduct for Law Enforcement Officials provide that law enforcement officials should apply non-violent means in carrying out their duties and only use force when strictly necessary.[140] When the use of force is unavoidable, it should be used in proportion to the seriousness of the offense and the legitimate objective to be achieved, and shall minimize damage and injury.[141] In any event, the intentional use of lethal force by law enforcement is permissible only when strictly unavoidable to protect life.[142] In carrying out the anti-drug operations described above, Thai and Brazilian law enforcement officials violated these basic provisions.

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**.[143] In December 2004, the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT) published its findings from a late-2002 visit to Ukraine, including that 'persons deprived of their liberty by the Militia [Ukraine's domestic law enforcement body] run a significant risk of being physically ill-treated at the time of their apprehension and/or while in custody of the Militia (particularly when being questioned), and that on occasion resort may be had to severe ill-treatment/torture.'[144] In its response to the CPT's report, Ukraine acknowledged police detectives' 'wrong understanding of crime disclosure rate as the main criteria of the efficiency of their work,' as a factor in police abuse, stating that this 'wrong understanding' was 'why some officers try to achieve the high crime disclosure by any means.'[145] 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. The UN Committee against Torture has expressed concern about 'the numerous convictions based on confessions' in Ukraine, as well as the fact that the 'number of solved crimes' is among the 'criteria for the promotion of investigators.' According to the Committee, this 'can lead to torture and ill-treatment of detainees or suspects to force them to 'confess''.[146] Domestic and international human rights bodies have also expressed concern that Ukraine's failure adequately to investigate, prosecute, or punish cases of police abuse created a climate of impunity that has permitted abusive policing practices to persist.[147] Unfortunately, the public condemnation of abusive police practices that have emerged from the human rights system in the UN have not been mirrored by similar comments from the organisation's drug control wing.

Police also use drug addiction as a tool to coerce incriminating testimony from drug users. A former senior detective specializing in drug enforcement cases, and attorneys and social workers to drug users in **Ukraine** have reported, for example, that 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

142 Basic Principles, principle 9.

143 Human Rights Watch, 'Rhetoric and Risk: Human Rights Abuses Impeding Ukraine's Fight Against AIDS', *A Human rights Watch Report*, Vol. 18, No. 2(D), March 2006 (Hereafter Rhetoric and Risk); Human Rights Watch, 'Lessons Not Learned: Human Rights Abuses and HIV/AIDS in the Russian Federation', A Human Rights Watch Report, Vol. 16, No. 5(D), April 2004 (Hereafter Lessons not Learned); Human Rights Watch, 'Fanning the Flames: How Human Rights Abuses Are Fuelling the AIDS Epidemic in Kazakhstan', A Human Rights Watch Report, Vol. 15, No. 4(D), June 2003 (Hereafter Fanning the Flames).

144 European Convention for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment, 'Report to the Ukrainian Government on the Visit to the Ukraine Carried out by the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment from 24 November to 6 December 2002', CPT/Inf (2004) 34, para 20. Generally, CPT reports of country visits are published only with the agreement of the State concerned, and accompanied by the State's response.

145 'Response of the Ukrainian Government to the report of the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment on its first visit to Ukraine from 24 November to 6 December 2002', CPT/Inf (2004) 35, p. 7.

146 United Nations Committee Against Torture, Conclusions and Recommendations: Ukraine, 25/09/2002, A/57/44,paras 54-58.

147 See, for example, CPT, 'Report to the Ukrainian Government on the Visit to the Ukraine', paras. 22, 23, op.cit.; U.S. Department of State, 'Country Report on Human Rights Practices: Ukraine 2004' (February 2004); Amnesty International, 'Ukraine. Time for Action: Torture and Ill-Treatment in Police Detention' (2005) http://www.amnesty.org/en/library/info/EUR50/004/2005 (Date of last access: 20 February 2008).

148 'Rhetoric and Risk' p. 33, op.cit.; Andriy Tolopilo, 'Reforming Drug Policy of the NIS to Prevent the Spread of AIDS', 2004 (Russian).

149 Human Rights Committee, General Comment 20, Article 7 (Forty-fourth session, 1992), *Compilation of General Comments and General Recommendations Adopted by Human Rights Treaty Bodies, U.N. Doc. HRI\GEN\1\Rev.1 at 30 (1994). The Human Rights Committee is the United Nations body charged with monitoring implementation of the International Covenant on Civil and Political Rights*. See also art. 1 CAT (defining torture to include intentional acts that cause severe physical pain or mental suffering) op.cit.

150 'Report of the Special Rapporteur on the question of torture and other cruel, inhuman or degrading treatment or punishment, U.N. General Assembly', U.N. Doc. A/56/156, July 3, 2001, Section IIA (finding that fear of physical torture may constitute mental torture, and that serious and credible threats to the physical integrity of the victim or a third person can amount to cruel, inhuman or degrading treatment, or even to torture, especially when the victim is in the hands of law enforcement officials).

through withdrawal.[148] People facing withdrawal may be especially vulnerable and, in order to avoid detention or secure release from confinement, may succumb to pressure to admit to false charges or confess guilt before having had access to counsel, been before a judge, or been able to digest and understand the potential charges and consequences against them.

International law unequivocally forbids the use of torture and other cruel, inhuman or degrading treatment or punishment by officials or persons acting in an official capacity. These prohibitions extend to conditions of confinement for prisoners, and apply 'not only to acts that cause physical pain but also to acts that cause mental suffering to the victim,'[149] including intimidation and other forms of threats.[150] International law also bars the use of statements obtained through torture as evidence, except against the person accused of torture.[151] This prevents law enforcement officials from being rewarded for using torture to extract information. It is also a way to ensure against self-incrimination, a right protected under international law.[152] International law also guarantees the right to liberty and security of the person and protection from arbitrary detention.[153] When police use drug addiction as a tool to coerce testimony or extort money from drug users suffering from withdrawal, and deny medical assistance to drug users in withdrawal, they similarly violate basic provisions against torture and cruel, inhuman, and degrading treatment or punishment.

In the **United Kingdom**, the *Drugs Act 2005* allows for compulsory testing for 'Class A' substances[154] if the person involved has been arrested for a 'trigger offence''. Trigger offences are generally acquisitive, fraud, or drug offences and include (but are not limited to) offences as wide ranging as theft and attempted theft; robbery and attempted robbery; car theft; going equipped for burglary; possession of a controlled drug; and begging or persistent begging. Compulsory testing may also be required if a senior officer has 'reasonable grounds' to believe that the person arrested has used class A drugs and that such use contributed to the commission of the offence.[155]

As noted by the UK non-governmental organisation Release, mandatory testing 'is not intended to prove or disprove the commission of an offence' and 'those who are subject to the mandatory testing may never be charged with the offence for which they were arrested, and may never have committed any offence'.[156] 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. There is no reference in the legislation to consent on the part of the person arrested, despite the fact that drug testing is an invasive procedure and, without justification and/or consent, is a considerable violation of the right to privacy and bodily integrity. Moreover, it may also violate the right to due process of law and the protection from self-incrimination.

Death Penalty for Drug Offences

The death penalty has been abolished in law or practice in 133 countries. Of the sixty-four 'retentionist' nations that continue to use capital punishment, nearly half have legislation applying the death penalty for drug-related offences.[157] Over the past twenty years, there has been a remarkable trend towards the abolition of capital punishment worldwide, with more and more countries ending the death penalty either in law or in practice. Yet during this same period the number of countries expanding the application of the death penalty to include drug offences has increased from twenty-two in 1985, to twenty-six in 1995, to at least thirty-four by the end of 2000. The majority of these countries are in the Middle East, North Africa and the Asia-Pacific regions, and in some, drug offences can carry a mandatory sentence of death.[158]

The number of people put to death annually for drug convictions is difficult to calculate. While not all countries implement the death

151 CAT, art 15. See also Body of Principles for the Protection of All Persons Under Any Form of Detention or Imprisonment, G.A. res 43/173, UN Doc no. A/RES/43/173 9 December 1988, principle 21.

152 ICCPR, art 14(3)(g).

153 ibid., art 9.

154 Drugs are classed as A, B and C under the UK's Misuse of Drugs Act (1971). Heroin, cocaine and ecstasy are considered class A, as are 'magic mushrooms'.

155 Drugs Act 2005 (c.17), s. 7(3).

156 Release, 'Briefing on the Drugs Bill 2005', February 2005, paras 15-29.

157 In 2001, the United Nations Commission on Crime Prevention and Criminal Justice identified Bahrain, Bangladesh, Brunei Darussalam, China, Cuba, Democratic Republic of Congo, Egypt, Guyana, India, Indonesia, Iran, Iraq, Jordan, Kuwait, Libya, Malaysia, Myanmar, Oman, Pakistan, Philippines, Qatar, South Korea, Saudi Arabia, Singapore, Sri Lanka, Sudan, Syrian Arab Republic, Taiwan, Tajikistan, Thailand, United Arab Emirates, the United States (federal law), Uzbekistan and Viet Nam as those countries with capital punishment for drug crimes. Commission on Crime Prevention and Criminal Justice, 'Capital punishment and implementation of the safeguards guaranteeing protection of the rights of those facing the death penalty' (29 March 2001) E/CN.15/2001/10, para 90.

158 R Hood *The Death Penalty: A World Perspective* (3rd ed OUP 2002) p. 81.

159 Amnesty International 'China' in Amnesty International Report 2005 (2005) http://web.amnesty.org/report2005/chn-summary-eng (1 May 2005) (AI 2005 Report); Amnesty International *The Death Penalty Worldwide: Developments in 2001* (2002) AI Index ACT 50/001/2002.

160 Commission on Crime Prevention and Criminal Justice, 2001, para 64., op.cit.

161 Amnesty International 'Death Penalty News' (December 2000) AI Index ACT 53/001/2001.

162 Amnesty International, 'The Death Penalty Worldwide: Developments in 2001' (2002) AI Index ACT 50/001/2002; Amnesty International 'Death Penalty News' (June 1998) AI Index ACT 53/03/98.

163 Amnesty International 'Southeast Asia: Execution of drug traffickers does not control the trade' Press release AI Index ASA 03/001/2001 - News Service Nr. 79 (9 May 2001); Amnesty International '*The Death Penalty Worldwide: Developments*' in 2001, op.cit.

sentences contained in legislation, a significant number of executions for drug offences take place each year. In recent years executions for drug offences have been carried out in numerous countries, including China,[159] Indonesia,[160] Malaysia,[161] Singapore,[162] Thailand[163] and Viet Nam[164]. In some of these countries, drug offenders constitute a significant proportion of total executions.

Despite the increasing application of the death penalty for drug offences and the use of the UN day against drugs for executions of drug offenders, neither the CND nor UNODC have publicly condemned the practice. While it may be that the issue simply has not been adequately brought to their attention, it is clear that policy guidance from the UN drug control machinery could be of great benefit in addressing the application of the death penalty for drugs. While capital punishment is not prohibited entirely under international law, its application is limited in significant ways. Under Article 6(2) of the *International Covenant on Civil and Political Rights* (ICCPR), the penalty of death may only be applied for the 'most serious crimes'. While many countries that retain the death penalty argue that drug crimes fall under this umbrella,[177] this suggestion has been rejected by UN human rights monitors.

BOX II: Application of the Death Penalty for Drug Offences

In **Malaysia**, between July 2004 and July 2005, thirty-six of the fifty-two executions carried out were for drug trafficking.[165] In April 2005, the Internal Security Ministry reported to the Malaysian parliament that 229 people had been executed for drug trafficking over the previous thirty years.[166]

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'.[167] According to a recent media report, 'Around 100 people are executed by firing squad in Viet Nam each year, mostly for drug-related offences'.[168] One UN human rights monitor commenting on the situation noted that 'Concerns have been expressed that at least one third of all publicised death sentences are imposed for drug-related crimes'.[169]

Since 1991, more than 400 people have been executed in **Singapore**, the majority for drug offences.[170] It has been reported that between 1994 and 1999, 76 per cent of all executions in Singapore were drug-related.[171] According to media reports, Singapore executed seventeen people for drug crimes in 2000, and twenty-two in 2001.[172]

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 2001, over fifty people were convicted and publicly executed for drug crimes at mass rallies, at least one of which was broadcast on state television.[173] 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.[174] A UN human rights monitor reported 'dozens' of people being executed to mark the day in 2004,[175] and Amnesty International recorded fifty-five executions for drug offences over a two-week period running up to 26 June 2005.[176]

164 Amnesty International 'Death Penalty News' (March 2003) AI Index ACT 53/002/2003.

165 C. S. Ling, 'Debate over the death penalty heating up', *New Straits Times* (26 March 2006).

166 '229 executed for drug trafficking in past 30 years', *Malasiakini* (13 April 2005) http://www.malaysiakini.com/news/35303.

167 UN Human Rights Committee, 'Comments by the Government of Viet Nam on the concluding observations of the Human Rights Committee' (21 July 2003) UN Doc CCPR/CO/75/VNM/Add.2 para. 1.

168 'Viet Nam law commission wants death penalty for fewer crimes', *Thanh Nien News* (3 November 2006).

169 UN Commission on Human Rights, 'Extrajudicial, summary or arbitrary executions: Report of the Special Rapporteur, Philip Alston, Addendum—Summary of cases transmitted to Governments and replies received' (27 March 2006) UN Doc E/CN.4/2006/53/Add.1 p.302.

170 Amnesty International, 'Singapore - The death penalty: A hidden toll of executions' (15 January 2004) AI Index ASA 36/001/2004.

171 The figures come from a written reply dated 12 January 2001 from the Minister for Home Affairs (Ninth Parliament of Singapore, Second Session). Cited in Commission on Crime Prevention and Criminal Justice, 2001, para 69. op.cit.

172 A. Tan, 'Singapore death penalty shrouded in silence', Reuters (12 April 2002).

173 Amnesty International, *The Death Penalty Worldwide: Developments in 2001*, p. 33. op.cit.

174 'China executes 64 to mark UN anti-drug day', *Associated Press* (27 June 2002).

175 UN Commission on Human Rights, 'Extrajudicial, summary or arbitrary executions: Report of the Special Rapporteur, Philip Alston, Addendum - Summary of cases transmitted to Governments and replies received' (17 March 2005) UN Doc E/CN.4/2005/7/Add.1 para 69.

176 Amnesty International, *Asia Pacific: Death sentences for drug-related crimes rise in region* (26 June 2007) public statement AI Index: ASA 01/004/2007 (Public) – News Service No. 114.

177 See Government of Singapore, Letter dated 27 June 1997 from the Permanent Mission of Singapore to the United Nations Office at Geneva addressed to the Special Rapporteur on Extrajudicial, Summary or Arbitrary Executions, (5 December 1997) E/CN.4/1998/113 para 3; UN Human Rights Committee 'Consideration of Reports Submitted by States Parties Under Article 40 of the Covenant: Initial Report: Thailand' (2 August 2004) UN Doc No CCPR/C/THA/2004/1 para 158.

The UN Human Rights Committee, the independent expert body which monitors state compliance with the obligations under the ICCPR, has questioned the application of capital punishment to drugs. In its 1995 report on **Sri Lanka**, the Committee specifically lists 'drug-related offences' among those that 'do not appear to be the most serious offences under article 6 of the ICCPR.'[178] The Committee's 1994 report on **Kuwait** also 'expresses serious concern over the large number of offences for which the death penalty can be imposed, including very vague categories of offences relating to internal and external security as well as drug-related crimes.'[179] Most recently, the Committee's 2005 report on **Thailand** states definitively that drug related offences do not meet this threshold, and expresses its 'concern that the death penalty is not restricted to the 'most serious crimes' within the meaning of article 6, paragraph 2, and is applicable to drug trafficking'.[180]

The Special Rapporteur on Extrajudicial, Summary or Arbitrary Executions has also stated that drug offences do not meet the threshold of 'most serious crimes', recommending that '[T]he death penalty should be eliminated for crimes such as economic crimes and drug-related offences.'[181] This conclusion was most recently reaffirmed in the Special Rapporteur's 2006 Annual Report.[182]

From the perspective of the UN human rights system there is little to support the suggestion that drug offences meet the threshold of 'most serious crimes'. In fact, the weight of opinion indicates clearly that drug offences are not 'most serious crimes' as the term has been interpreted, and that therefore the execution of people for drug-related offences violates international human rights law. By carrying out death sentences in such dubious legal circumstances, countries that execute drug offenders do so in circumstances likened by a UN Special Rapporteur to summary or arbitrary executions.[183]

Demand Reduction

Detention and Coercive Drug Treatment

Detention of drug users without trial violates basic principles of international law, yet this violation has been documented in many countries. In 2006, for example, the European Court of Human Rights found in favour of a HIV-positive and epileptic Russian drug user who was detained without trial for over a year without trial or proper medial attention. He had purchased 0.05g of heroin from an undercover police officer. It was held that the applicant's rights to a fair trial and freedom from ill treatment had been violated.[184]

Article 9 of the ICCPR provides that any person 'deprived of his liberty by arrest or detention shall be entitled to take proceedings before a court, in order that that court may decide without delay on the lawfulness of his detention and order his release if the detention is not lawful.'[185] The UN Human Rights Committee has interpreted this provision to apply 'to all deprivations of liberty, whether in criminal cases or in other cases such as, for example, mental illness, vagrancy, drug addiction, educational purposes, immigration control, etc.'[186] Article 14 of the ICCPR provides basic fair trial rights, including the right to a public hearing; to be presumed innocent until proven guilty; and to review in case of criminal conviction 'by a higher tribunal according to law.[187] The UN Body of Principles for the Protection of All Persons Under Any Form of Detention similarly requires that persons 'not be kept in detention without being given effective opportunity to be heard promptly by a judicial or other authority. A detained person shall have the right to defend himself or to be assisted by counsel as prescribed by law.'[188]

In many countries people who use drugs can face coerced 'treatment' and 'rehabilitation'. Rather than being discouraged, such mandatory treatment is specifically permitted in the 1961 Single Convention on Narcotic Drugs. Article 36.1(b) states that in addition to or instead of punishment, states parties 'may provide' that drug users who have committed a crime 'shall undergo measures of treatment'. The provision does also refer to 'education, after care, rehabilitation and social reintegration',[189] which suggests a more progressive approach, but unfortunately, forced treatment (or 'rehabilitation') can and does result in significant human rights abuses.

178 UN Human Rights Committee, 'Concluding observations of the Human Rights Committee: Sri Lanka', (26 July 1995) UN Doc A/50/40 s. 4.

179 UN Human Rights Committee, 'Concluding observations of the Human Rights Committee: Kuwait', (27 July 2000) UN Doc CCPR/CO/69/KWT para 13.

180 UN Human Rights Committee, 'Concluding observations of the Human Rights Committee: Thailand', (8 July 2005) UN Doc No CCPR/CO/84/THA para 14.

181 Commission on Human Rights, 'Report by the Special Rapporteur, Mr. Bacre Waly Ndiaye, submitted pursuant to Commission on Human Rights resolution 1996/74', (24 December 1996) UN Doc E/CN.4/1997/60 para 91.

182 UN Human Rights Council, 'Report of the Special Rapporteur on extrajudicial, summary or arbitrary executions, Philip Alston', (29 January 2007) UN Doc A/HRC/4/20 paras 51–53.

183 UN Commission on Human Rights, 'Report of the Special Rapporteur on extrajudicial, summary or arbitrary executions', (22 December 2003) UN Doc. E/CN.4/2004/7 para 48.

184 Khudobin v Russia, App No. 59696/00, 26 October 2006.

185 ICCPR, art 9.

186 Human Rights Committee, 'General Comment 8, Article 9' (Sixteenth session, 1982), *Compilation of General Comments and General Recommendations Adopted by Human Rights Treaty Bodies*, U.N. Doc. HRI\GEN\1\Rev.1 para 8 (1994).

187 ICCPR, arts 14 (1), (2), (5).

188 'Body of Principles for the Protection of All Persons under Any Form of Detention or Imprisonment', principle 11 (1), op.cit.

189 1961 Single Convention art 36(1)(b).

The law in **China**, for example, dictates that 'drug users must be rehabilitated.' Those arrested for drug possession and use can be consigned to forced detoxification centres without any trial or other semblance of due process. Once inside, detainees are required to perform unpaid, forced labour, which violates the ICCPR.[190] Detainees are also subject to mandatory testing for HIV and other sexually transmitted infections and to militarised psychological and 'moral education', and are housed in unsanitary and overcrowded conditions. Detainees are not provided with HIV test results, or with treatment or HIV prevention counselling, notwithstanding State Council policy providing for medical treatment.[191] Investigations have uncovered extreme ill-treatment in the name of 'rehabilitation', such as the administering of electric shocks while viewing pictures of drug use.[192] It is estimated that 90-100% of persons subjected to forced treatment return to drug use,[193] and a 2004 survey found that 9% of 3,213 Chinese heroin users had taken extreme steps such as swallowing glass to gain a medical exemption from forced treatment.[194]

Throughout its 2003 'war on drugs,' the government in **Thailand** took a number of coercive steps to force people to enrol in drug treatment programs. Initially, the Thai government mandated that all drug users attend drug treatment. Those that did not 'volunteer' for treatment during the first few months of the war on drugs were subject to arrest and compulsory treatment, and placed on blacklists that were widely publicized throughout local communities and shared with local police. 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. Others stayed away from treatment for fear of being identified as a drug user and subsequently targeted for arrest or worse. A survey of 3,066 people who attended state-run rehabilitation centres during the height of the war on drugs found that 6% had never used any illicit drug before, and 50% had stopped using before the war on drugs began.[195] The Thai government required that national and regional health authorities, and district and community hospitals and health clinics throughout the country assist with identification and 'treatment' of drug users. The Royal Thai Army, the Ministry of Public Health, and the Ministry of Justice were all engaged in these efforts.

Supply Reduction

Forced Crop Eradication

The world's supply of crop-based illegal drugs is provided by a relatively small number of developing countries. The South American countries of Colombia, Peru, and Bolivia are the primary source of coca, the raw material for cocaine, while poppy, the raw material for opium and heroin, is grown primarily in Afghanistan and to a lesser extent in Myanmar (Burma). Pakistan, the Lao People's Democratic Republic, Colombia and Mexico have smaller or very small levels of poppy cultivation.

Both coca-growing and poppy-growing regions are characterized by poor conditions for sustainable agricultural production of other crops, lack of infrastructure and poor accessibility. For the most part, small farmers grow food for subsistence and a small amount of coca or poppy as their only source of cash income. It allows for additional purchases of food and basic supplies, but living conditions for the families involved are often barely at subsistence level. Yet these farmers are more often than not considered and treated as criminals. In fact, it is often easier to target law enforcement efforts at small farmers rather than the drug traffickers who have the resources to bribe and coerce police and other officials.

In Latin America to date, forced eradication of coca crops – including aerial spraying of herbicides in **Colombia** – has had little long-term impact on the illicit drug market. While some short-term gains have been achieved, these have proven unsustainable in the medium- or long-term as crops are quickly replanted, or cultivation displaced to other areas. More often than not, lacking viable economic alternatives, poor farmers replant. They often begin utilizing smaller plots and interspersing coca or poppy plants under vegetation that makes it harder to detect. Moreover, the emergence and spread of higher yield crops means that more illicit drugs can be produced from smaller plots.

The eradication of coca or poppy crops, upon which farmers and their families depend, prior to the establishment of alternative sources of cash income pushes people deeper into poverty. In this sense, international drug control programs directly conflict with

190 ICCPR, art 8(1). Art 8 permits convicted criminals to be required to work as part of their punishment. Detainees in forced detoxification centres, however, have not been convicted of a crime in a court of law, and are therefore not covered by this provision. International standards on the treatment of detainees further require that work undertaken be to prisoners' benefit. See Basic Principles for the Treatment of Prisoners, G.A. res. 45/111, annex, 45 U.N. GAOR Supp. (No. 49A) p. 200, U.N. Doc. A/45/49 (1990), art 8.

191 See Human Rights Watch, 'Locked Doors: The Human Rights of People Living with HIV/AIDS in China', *A Human Rights Watch Report*, Vol. 16, No. 7(C), New York, August 2003, pp. 42-49. (Hereafter Locked Doors).

192 Daniel Wolfe 'Paradoxes in antiretroviral treatment for injecting drug users: Access, adherence and structural barriers in Asia and the former Soviet Union', *International Journal of Drug Policy* 18 (2007) 246-254, p. 250 (Hereafter Paradoxes in antiretroviral treatment).

193 Crofts, N 'Treatment in Southeast Asia: The need for effective approaches', in *Open Society Institute Briefing on Drug Treatment, HIV and the Challenge of Reform*, 2006.

194 Juny et al. 'Analysis of 272 cases of swallowing foreign body in compulsory detoxification', *China Journal of Drug Dependence*, 13(3), pp. 221-223.

195 See Human Rights Watch, 'Not Enough Graves: The War on Drugs, HIV/AIDS, and Violations of Human Rights', *A Human Rights Watch Report*, Vol. 16, No. 8(C) (June 2004), p. 32. (Hereafter Not Enough Graves).

196 'Thematic Evaluation of UNODC's Alternative Development Initiatives', Independent Evaluation Unit of the UNODC, November 2005, pp. 23 – 24.

197 'Alternative Development: A Global Thematic Evaluation', Final Synthesis Report, UNODC, March 2005, p. 9.

the development objectives of other UN agencies such as the UN Development Program (UNDP) and multilateral institutions such as the World Bank. In most cases, forced eradication has far outpaced the provision of economic alternatives, devastating communities in Latin America and Asia. The loss of the only source of cash income forces families to sell off livestock and land, and to abandon school and health services.

For example, research conducted in 2002 and 2003 by the UNODC and published in 2005 in the Kokang Special Region 1 in **Myanmar (Burma)** found that 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.'[196] 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.[197]

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. Many Afghan farmers are plagued with poppy-related debt that requires them to continue cultivation and can even lead to farmers being forced to sell their under-age daughters in marriage to repay it. 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.'[198]

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. In addition to fuelling political violence and conflict, as noted above, there is ample reason for concern that spraying causes serious harm to the environment and human health, both immediately and in the long-term. Collecting data on health complaints in areas where fumigation occurs is difficult as causality is very hard to determine. However, local health workers in Colombia often report increased skin, respiratory and gastrointestinal problems following aerial spraying. While the scientific evidence is not yet definitive, the widespread perception among Ecuadorians and Colombians alike is that fumigation jeopardizes the region's water sources and rich biodiversity.

The issue remains a subject of heated debate internationally. A 2005 study by the Organization of American States (OAS) that declared spraying to be relatively safe is widely questioned; in response, the government of Ecuador asked the UN for assistance in determining the impact of fumigation along its border with Colombia. Upon his recent election, President Raphael Correa has renewed efforts to force Colombia to cease spraying along its border with Ecuador because of the environmental and health impacts on the Ecuadorian side.

The damage often inflicted upon legal food crops – and hence food security for a very vulnerable segment of the population – is also cause for concern. In addition to food crops that are targeted directly because they are interspersed with coca, spray drift leads to the unintended consequence of spraying legal crops and cattle-grazing fields, as the U.S. government admits. One investigation found that in 2002 and 2003, aerial spraying caused significant damage to food crops, pasture, livestock, and agricultural development projects.[199] Although a programme is in place to provide compensation in these cases, very few of those who have complained actually receive it. According to the U.S. State Department, of approximately 5,500 complaints filed between 2001 and 2005, only twelve individuals received compensation.[200]

The human rights impact of aerial crop eradication has been identified as an issue of concern by several UN human rights bodies. For example, 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'.[201] The Committee recommended 'that [Colombia] carry out independent, rights-based environmental and social-impact assessments of the sprayings in different regions of the country and ensure that, when affected, prior consultation is carried out with indigenous communities and that all precautions be taken to avoid harmful impact of the health of children.'[202]

198 'Afghanistan – State Building, Sustaining Growth and Reducing Poverty', *A World Bank Country Report*, 2005, pp. 118 – 119. http://siteresources.worldbank.org/INTAFGHANISTAN/Resources/0821360957_Afghanistan--State_Building.pdf (Date of last access: 21 February 2008).

199 Betsy Marsh, 'Going to Extremes: The U.S. Funded Aerial Eradication Program in Colombia', The Latin America Working Group Education Fund, February 2004, p. 2.

200 U.S. Department of State, 'International Narcotics Control Strategy Report', March 2005, www.state.gov/p/inl/rls/nrcrpt/2005/ (Date of last access: 21 February 2008).

201 UN Committee on the Rights of the Child, 'Concluding observations: Colombia', (8 June 2006) UN Doc No CRC/C/COL/CO/3 para 72.

202 For more on human rights impact assessments, see below, Part III.

The UN Special Rapporteur on the Right to Health raised concerns in 2007 about the impact of aerial crop eradication activities along the Colombia/Ecuador border. In 'looking at this issue through the prism of the right to health', the Special Rapporteur recommended that the aerial spraying of glyphosate by the Colombian government should be discontinued as the activity 'jeopardise[d] the enjoyment of the right to health in Ecuador', as well as damaging the physical and mental health of people living in Ecuador. According to the Special Rapporteur, 'It is imperative that when considering this very important issue the human right to health – at root, the well-being of disadvantaged individuals and communities – is placed at the centre of all decision-making.'[203]

The UN Working Group on Mercenaries[204] raised concerns about crop eradication in its 2007 report on its mission to **Ecuador**, which investigated the question of private military and private security companies (PMSCs) violating human rights. The report noted a PMSC was contracted to carry out aerial spraying in Colombia, and cited research evidence of the negative impact of these activities on human health.[205] Noting that some of the relevant domestic human rights law in Colombia excludes the activities of private corporations, the Working Group raised the concern 'that some States could be hiring PMSCs in order to avoid direct legal responsibilities.'[206] The Working Group stated that this legal loophole in the case of aerial crop eradication 'highlights the need to prepare international basic principles to ensure that private companies promote the respect of the human rights in their activities.'[207]

It must be noted that the UNODC does not support 'forced' eradication programmes and focuses instead on 'alternative development' schemes 'intended to promote lawful and sustainable socio-economic options for those communities and population groups that have resorted to illicit cultivation as their only viable means of obtaining a livelihood, contributing in an integrated way to the eradication of poverty'.[208] Indeed, the 1998 UNGASS Action Plan on International Co-Operation on the Eradication of Illicit Drug Crops and on Alternative Development notes: '[i]n areas where alternative development programmes have not yet created viable alternative income opportunities, the application of forced eradication might endanger the success of alternative development programmes'.[209] Forced eradication, however, is not expressly prohibited by the international drug control conventions. In fact, Article 14(2) of the 1988 Convention requires that 'Each Party shall take appropriate measures…to eradicate plants containing narcotic or psychotropic substances, such as opium poppy, coca bush and cannabis plants, cultivated illicitly in its territory'. The article goes on to state that '[t]he measures adopted shall respect fundamental human rights and shall take due account of traditional licit uses, where there is historic evidence of such use, as well as the protection of the environment'. However, there is no mention of consent to such actions by local or indigenous communities and it is more than clear from the cases above that the requirement of eradication has taken priority over the respect for human rights.

Drug Policies Undermining HIV Prevention, Treatment, Care and Support

Harm Reduction

Individuals who use drugs do not forfeit the right to the highest attainable standard of health. Nor does the prohibited legal status of the drug(s) in question remove the obligation of states parties to meet their obligations to respect, protect and fulfil this right for all persons within their jurisdiction, including people who use illegal drugs. Despite this obligation in international law, the rhetoric of drug control has often been used to undermine the right to health, particularly in the area of the prevention of blood-borne diseases such as HIV and hepatitis C virus (HCV), both of which are easily transmitted by unsafe injecting drug practices such as the sharing of syringes.

The overwhelming international consensus, based on two decades of scientific research, is that comprehensive harm reduction measures, including syringe exchange and substitution treatment, can drastically reduce the transmission of HIV and other blood-borne viruses.[210] Harm reduction has been adopted in the policies of UNAIDS, the World Health Organization and the UNODC.[211] Yet in many

203 P Hunt, Oral Remarks to the Press, Friday 21 September 2007, Bogota, Colombia (21 September 2007) http://www.hchr.org.co/documentoseinformes/documentos/relatoresespeciales/2007/ruedadeprensaingles.pdf (Date of last access: 7 January 2008).

204 The Working Group's full title is 'Working Group on the question of the use of mercenaries as a means of violating human rights and impeding the exercise of the right of peoples to self-determination'. Working Group on Mercenaries is used in this report as shorthand.

205 Working Group on the question of the use of mercenaries as a means of violating human rights and impeding the exercise of the right of peoples to self-determination, Mission to Ecuador, UN Doc No A/HRC/4/42/Add.2 paras 47-51.

206 ibid., para. 51.

207 ibid.

208 'Action Plan on International Co-Operation on the Eradication of Illicit Drug Crops and on Alternative Development', UN Doc A/RES/S-20/4, 8 September 1998, para 17.

209 ibid., para 31.

210 See, for example, A Wodak and A Cooney 'Effectiveness of sterile needle and syringe programming in reducing HIV/AIDS among injecting drug users' (2004) World Health Organization; D Burrows 'High coverage sites: HIV prevention among injecting drug users in transitional and developing countries' (2006) *UNAIDS Best Practice Collection*; Committee on the Prevention of HIV Infection among Injecting Drug Users in High-Risk Countries 'Preventing HIV Infection among Injecting Drug Users in High Risk Countries: An Assessment of the Evidence' (2006) National Academy of Sciences.

211 See WHO, UNAIDS and UNODC 'Evidence for Action Policy Brief: The provision of sterile injecting equipment to reduce HIV transmission', http://www.wpro.who.int/NR/rdonlyres/BA463DB4-2390-4964-9D86-11CBABCC9DA9/0/provisionofsterileen.pdf (Date of last access: 20 February 2008).

countries around the world, the development and mainstreaming of harm reduction programmes is hampered by the prohibitionist policies that drive domestic and international approaches to drug use. This undermines the realisation of the right to health for people who use drugs worldwide.

Indeed, harm reduction has become somewhat of a 'political football' in drug policy circles, as interventions intended to promote the heath of people who use illegal drugs represent the clearest and most widespread departure from zero tolerance policies that focus exclusively on minimising or eradicating drug use and drug markets. As a result, in both high-income and low-income countries across all regions of the world, people who inject drugs are often put at increased risk of preventable HIV and HCV infection by policies that deny harm reduction measures and that prioritise drug prohibition over human rights.

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.[212] 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.[213] 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**, for example, the war on drugs has had a lasting impact on drug users' access to fundamental health care services. Studies reported a significant decline in the number of people seeking treatment for drug use during the war on drugs, and that a significant percentage of people who had formerly attended drug treatment centres went into hiding, in some cases sharing syringes because sterile syringes were difficult to obtain.[214]

Many people who use drugs will not seek treatment at public hospitals out of fear that their drug use (past or current) will be shared with police. This fear is not unfounded. Public hospitals and drug treatment centres collect and share information about individuals' drug use with law enforcement, both as a matter of policy and in practice.[215] People who use drugs also reported that they used private clinics when seeking treatment for anything that might reveal their status as drug users (such as for treating abscesses or obtaining methadone). Not only is this costly, but it also means that they are less likely to obtain information about government-funded HIV/AIDS services (including low cost-antiretroviral treatment) to which they are entitled.[216]

In many instances, perceived threats from law enforcement are enough to drive people who use drugs away from HIV prevention programmes. A recent study of HIV prevention efforts along the border between **China** and **Viet Nam** showed clearly the delicate balance between law enforcement and HIV prevention efforts.[217] Interviews with peer educators and people who inject drugs undertaken during the study indicated that 'crackdowns and elevated enforcement activities from late 2003 into 2004 resulted in arrest of many IDUs…and drove others underground or prompted them to leave the area at least temporarily'.[218] The project had, in fact, gained the official support of the police and government agencies. Both countries, however, have some of the most stringent drug control legislation in the world and both retain the death penalty for drug offences. Moreover, both actively execute drug offenders. The perceived threat from law enforcement in such circumstances is entirely legitimate.

Increasingly, UN human rights monitors have begun to interpret the provision of harm reduction interventions as necessary for states to be compliant with the right to health under Article 12 of the *International Covenant on Economic, Social and Cultural Rights*.

212 See Scott Burris et al., 'Addressing the 'Risk Environment' for Injection Drug Users: The Mysterious Case of the Missing Cop', *The Milbank Quarterly*, vol. 82, no. 1 (2004), pp. 131-35 (reviewing studies); R. Pollini et al., 'Syringe Possession Arrests are Associated with Receptive Sharing in Two Mexico-US Border Cities', *Addiction* (2007), vol. 103, pp. 101-108; Joanne Csete 'Do Not Cross: Policing and HIV Risk Faced by People Who Use Drugs', Canadian HIV/AIDS Legal Network, 2007, http://www.aidslaw.ca/publications/interfaces/downloadFile.php?ref=1080 (Date of last access: 19 February 2008).

213 A survey of drug users in five Russian cities found that 40 percent routinely did not carry injection equipment, in part out of fear of attracting police attention. Jean-Paul C. Grund, 'Central and Eastern Europe', in HIV AND AIDS: A GLOBAL VIEW, Karen McElrath, (ed) (Westport, Connecticut: Greenwood Press, 2002), pp. 41-67. See also studies cited in Addressing the 'Risk Environment' for Injection Drug Users, pp. 131-35; and Human Rights Watch: 'Lessons Not Learned' pp. 28-31; 'Fanning the Flames' pp. 32-34; 'Not Enough Graves' pp. 36-42 and 'Rhetoric and Risk' pp. 34-40, op.cit.

214 Not Enough Graves, pp. 36-37, op.cit.; and E-mail communication from Swarap Sarkar, regional director, UNAIDS-South Asia to Human Rights Watch, May 18, 2004 (on file with authors). Researchers have also found that the government crackdown on drug users was likely to discourage drug users from obtaining HIV testing and other medical services. Tassanai Vongchak et al., 'The influence of Thailand's 2003 'war on drugs' policy on self-reported drug use among injection drug users in Chiang Mai, Thailand,' *International Journal of Drug Policy*, No. 16 (2005), pp. 115–121.

215 Human Rights Watch and Thai AIDS Treatment Action Group, 'Deadly Denial: Barriers to HIV/AIDS Treatment for People Who Use Drugs in Thailand', November 2007 pp. 20-24. (Hereafter Deadly Denial).

216 ibid., p. 21

217 T. Hammett et al 'Law Enforcement Influences on HIV Prevention for Injecting Drug Users : Observations from a cross-border project in China and Viet Nam', *International Journal of Drug Policy*, 16 (2005) pp. 235-245.

218 ibid., p. 242

For example, in the November 2006 report on **Tajikistan** from the UN Committee on Economic, Social and Cultural Rights, the Committee expressed concern at 'the rapid spread of HIV in the State party, in particular among drug users, prisoners, [and] sex workers', and specifically called upon the government to 'establish time-bound targets for extending the provision of free…harm reduction services to all parts of the country.'[219] The World Health Organization, UNODC, and UNAIDS criticized **Ukraine's** efforts to introduce medication assisted therapy with buprenorphine to 200 people by end 2005 as 'grossly insufficient' to address the needs of opiate-dependent drug users. The agencies recommended that the government 'do everything in its power to simplify the introduction and scale up' of methadone and buprenorphine programs to between 60,000 and 238,000 people.[220] In 2007, the Committee raised similar concerns in its report on Ukraine [221], stating it was 'gravely concerned about the high prevalence of HIV/AIDS epidemic in the State party, including among…high risk groups such as sex workers, drug users and incarcerated persons…and the limited access by drug users to substitution therapy.' The Committee recommended that the government 'make drug substitution therapy and other HIV prevention services more accessible for drug users.'[222]

One of the strongest statements in this regard was made by the UN Special Rapporteur on Health, Professor Paul Hunt, following his mission to **Sweden** in 2007. In his report on Sweden's compliance with its obligations under Article 12, the Special Rapporteur stated that harm reduction is not only an essential public health intervention, but that it 'enhances the right to health' of people who inject drugs.[223] Stating that the provision of harm reduction programmes was 'an important human rights issue', Professor Hunt said was 'very surprised' at the small number of needle exchange programmes in Sweden, as these interventions have been endorsed by UNAIDS, the WHO and UNODC and 'emphasis[ed] that the Government has a responsibility to ensure the implementation, throughout Sweden and as a matter of priority, of a comprehensive harm reduction policy, including counselling, advice on sexual and reproductive health, and clean needles and syringes'.[224]

Despite direction from the UN human rights system that countries that do not provide harm reduction measures are failing in their legal obligations under international human rights law, political pressures operating within the UN drug control regime has often hindered overt support for harm reduction approaches. This hardly makes for a human rights- or harm reduction-friendly global policy environment.

As noted above, the CND chooses to work on a consensus system whereby any member of the Commission, including those staunchly committed to prohibition, can block resolutions seen as tempering or balancing prohibition with other concerns. As a result, efforts to inject human rights principles into CND decision-making have seen limited success to date, such as recent resolutions on preventing HIV among injecting drug users that contain only passing reference, in preambular paragraphs, to the *Universal Declaration of Human Rights*.[225]

At the operational level, the implications of law enforcement for HIV prevention (and the reduction of other harms associated with drug use) is particularly important for an agency such as UNODC, which is tasked both with carrying out the UN's drug enforcement activities as well as being its lead agency on HIV in the context of drug use (as a co-sponsor of the Joint UN Programme on HIV/AIDS). The tension between prohibition on the one hand, and health and human rights concerns on the other, is manifest in the work of the agency. UNODC's long-running dependence on funding from prohibitionist states such as the US, Sweden, Italy and Japan has also limited the agency's public support for harm reduction, including on human rights grounds.[226] Although UNODC declares itself to be guided both by the prohibitionist drug control conventions and the UN's human rights norms, at least insofar as its work on HIV prevention and 'drug abuse' is concerned, it has made little attempt to reconcile the inherent contradictions between the two. Ironically, the Special Rapporteur on Health's report on Sweden,[227] which criticised the country's failure to provide harm reduction measures on human rights grounds, coincided with the release of a UNODC report applauding Sweden's zero tolerance approach and promoting it as an example of successful prohibitionist (and anti-harm reduction) policies.[228]

219 Committee on Economic, Social and Cultural Rights, 'Concluding Observations: Tajikistan', (24 November 2006) UN Doc No E/C.12/TJK/CO/1, para 70.

220 WHO, UNAIDS, UNODC, 'Joint WHO/UNAIDS/UNODC Mission on Opioid Substitution Therapy in Ukraine', p. 7. Ukraine has taken some positive steps to improve access to antiretroviral therapy to drug users (including by taking steps to integrate buprenorphine and antiretroviral treatment programmes), but at this writing, methadone remains unavailable in Ukraine, and drug users continue to face barriers to care. In December 2007, President Yushchenko began to engage very pro-actively on HIV/AIDS policy. Most notably, restrictions on methadone import were lifted in December 2007, with Yushchenko's leadership on the issue. This will allow for methadone-based substitution maintenance therapy programmes to begin in Ukraine and for considerable expansion in delivery of this service.

221 Committee on Economic, Social and Cultural Rights, 'Concluding Observations: Ukraine', (23 November 2007) UN Doc No E/C.12/UKR/CO/5, para. 28.

222 ibid., para. 51.

223 'Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, Paul Hunt, Mission to Sweden' (28 February 2007) UN Doc No A/HRC/4/28/Add.2 para 60.

224 ibid., para 62.

225 CND resolutions 47/2, 48/12 and 49/4, op.cit.

226 EH Jensema & FE Thoumi,, 'Drug policies and the funding of the United Nations office on drugs and crime'. In *Global drug policy: Building a new framework*. The Senlis Council. 2004.

227 Report of the Special Rapporteur on the Right to the Highest Attainable Standard of Health: Mission to Sweden, op.cit.

228 UN Office on Drugs and Crime, ' Sweden's Successful Drug Policy: A review of the evidence', February 2007, http://www.unodc.org/pdf/research/Swedish_drug_control.pdf (Date of last access: 20 February 2007).

In a very positive move, the UNODC has recently released a discussion paper on 'Reducing the adverse health and social consequences of drug abuse' which stands as the strongest statement to date from the agency of its support for harm reduction.[229] It notes the UNODC's support for substitution treatment and needle exchange, as well as other harm reduction interventions and overdose treatment. While this is clearly a positive step, it does not go so far as to support safe injecting sites, despite the fact that they have been deemed legal under the international drug conventions by the UNDCP's own legal experts (see below). The UNODC paper also reiterates that harm reduction measures must be in line with the international drug control conventions but does not mention human rights, apart from a brief mention of the 'right to be healthy' (which is not the accepted understanding of the right to the highest attainable standard of health under international law). Unfortunately, the document is also an example of stigmatising language, referring to people who use drugs as 'drug abusers'. Such language reinforces negative views of some of the most marginalised populations and can contribute to discriminatory practices.

In addition to a record of praising states that violate human rights in the name of drug control,[230] the INCB also has a long history of opposition to harm reduction,[231] stating its view that 'some so-called 'harm reduction' approaches are not what they seem to be in that they cause more harm than they purport to reduce.'[232] For example, the INCB has been harshly critical of safe injecting facilities, alleging that such health programmes 'could be considered to be in contravention of the international drug control treaties by facilitating, aiding and/or abetting the commission of crimes involving illegal drug possession and use, as well as other criminal offences, including drug trafficking.'[233] Such statements disregard the findings of the Legal Affairs section of the UN International Drug Control Programme, from which INCB itself requested a legal opinion in 2002 on whether harm reduction interventions were compatible with the UN drug conventions. The UNDCP's legal experts concluded that the provision of syringe exchange, substitution treatment and safe injection facilities did not violate state obligations under the drug control treaties.[234] Despite this finding, the INCB 'has used its influence to pressure countries to reverse or delay implementation of safe injection facilities, and even to threaten UN personnel who support such facilities.'[235]

Prisons, Harm Reduction and the Right to Health

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.[236] Any such restrictions must be justified, for example, on well-founded considerations related to security. The UN Human Rights Committee, the expert body that monitors compliance with the ICCPR and provides authoritative interpretations of its provisions, has stated for example that 'Persons deprived of their liberty enjoy all the rights set forth in the [ICCPR], subject to the restrictions that are unavoidable in a closed environment.'[237] Prisoners, therefore, like all other persons, enjoy the right to life, to the highest attainable standard of health, and the right to be treated with dignity and protection against torture and cruel, inhuman, or degrading treatment and punishment.

By holding persons in custody, the state accepts positive obligations to protect their lives and well-being. The UN Human Rights Committee has stressed that 'the State Party by arresting and detaining individuals takes the responsibility to care for their life. It is up to the State party by organizing its detention facilities to know about the state of health of the detainees as far as may be reasonably expected. Lack of financial means cannot reduce this responsibility.'[238] Therefore, according to the Committee, it is 'incumbent on States to ensure the right to life of detainees, and not incumbent on the latter to request protection.'[239]

The Convention against Torture proscribes acts committed by public officials, as well as acts committed with their 'acquiescence.' In other

229 UN Office on Drugs and Crime, 'Reducing the adverse health and social consequences of drug use: A comprehensive approach' 2008, http://www.unodc.org/documents/prevention/Reducing-adverse-consequences-drug-abuse.pdf (Date of last access: 20 February 2008).

230 'Closed to Reason', pp. 14 & 15, op.cit.

231 For the most comprehensive analysis to date of the INCB's statements and positions on HIV prevention among injecting drug users, see 'Closed to Reason'.

232 International Narcotics Control Board, 'Report of the International Narcotics Control Board for 2003', E/INCB/2003/1 (Vienna, 2004); International Narcotics Control Board, Background release, February 27, 2004; International Narcotics Control Board, Annual report for 2005, para 185.

233 International Narcotics Control Board, 'Report of the International Narcotics Control Board for 2000', paras 176–177.

234 UNDCP Legal Affairs Section, 'Flexibility of treaty provisions as regards harm reduction approaches'. See also Closed to Reason, p. 9 op.cit.

235 Closed to Reason p. 13. op.cit. The absence of safe injecting sites in the recent UNODC discussion paper on harm reduction may well be due to pressure from the INCB which was consulted closely in the preparation of the document.

236 United Nations Human Rights Committee, General Comment No. 21: 'Humane treatment of persons deprived of liberty' (Art. 10), (April 10, 1992) *Compilation of General Comments and General Recommendations Adopted by Human Rights Treaty Bodies*, HRI/GEN/1/Rev.7, para 3; see also European Court of Human Rights (ECHR), *Gelfmann v. France*, no. 25875/03, Judgment of 14 December 2004, para 50.

237 ibid.

238 United Nations Human Rights Committee (UNHRC). (2002). *Lantsova v. Russian Federation*. 763/1997, UNCHR 74th session (2002), UN Doc.Ccpr/C/74/763/1997, para 9.2.

239 ibid.

words, international human rights law bars the state from tolerating acts or perpetuating conditions that amount to torture or ill-treatment. In prison, where most material conditions of incarceration are directly attributable to the state and where prisoners have been deprived of their liberty and means of self-protection, the requirement to protect individuals from risk of torture and other ill-treatment can give rise to a positive duty of care, which has been interpreted to include effective methods of prevention, screening, and treatment for life-threatening diseases.[240]

In its General Comment No. 14 on the Right to Health, the UN Committee on Economic, Social and Cultural Rights repeatedly stresses the importance of states' obligations to ensure equality of access to health facilities, goods, and services to all persons, 'especially the most vulnerable or marginalized sections of the population' without discrimination on any of the prohibited grounds.[241] The Committee notes in particular government obligations to 'refrain from denying or limiting equal access for all persons, including prisoners or detainees. . . to preventive, curative, and palliative health services,' and to abstain from 'enforcing discriminatory practices as State policy.'[242]

In some cases, state obligations to safeguard the lives and health of people in custody, and to protect them from ill- treatment, including inhuman and degrading treatment may require states to ensure a higher standard of care to prisoners than they may have access to outside prison, where they are not wholly dependent upon the state for protection of their health and welfare.[243] The prohibition on inhuman or degrading treatment specifically 'compels authorities not only to refrain from provoking such treatment, but also to take the practical preventive measures to protect the physical integrity and the health of persons who have been deprived of their liberty.'[244] Failure to provide adequate medical treatments to a detainee in prison may contribute to conditions amounting to 'inhuman or degrading treatment.'[245] In the case of opioid-dependent prisoners, states must take positive measures to protect against serious suffering, as well as to protect against HIV, hepatitis C and other serious diseases attendant upon drug dependence.

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. When in custody, people who use drugs face increased barriers to accessing health care and HIV prevention measures. Furthermore, the high prevalence of incarceration as a punishment for drug use can drive prison overcrowding, and contribute to making prisons a key site for the transmission of HIV, hepatitis C and tuberculosis.[246]

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 blood-borne viruses.

In this context, the failure to provide access to evidence-based harm reduction measures (including sterile syringes and medication assisted treatment with methadone or buprenorphine) may result in violations of these basic obligations to protect prisoners from exposure to inhuman or degrading treatment. Withholding access to sterile syringes and to methadone or buprenorphine maintenance therapy increases the risk of sharing injection equipment, and in turn, vulnerability to HIV/AIDS and hepatitis, both incurable and potentially fatal diseases. Unassisted opioid detoxification also increases the risk of fatal overdose if individuals relapse to drug use, as is often the case. Failure to take measures to ensure these harm reduction measures for prisoners thus threatens the right to life by putting prisoners at risk of premature death by overdose, and of HIV/AIDS and other life-threatening illnesses.

240 See, e.g. European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT), CPT Standards, CPT/Inf/E (2002) 1 – Rev. 2006, p. 29.

241 UN Committee on Economic, Social and Cultural Rights, General Comment No. 14, para 12 (b).

242 ibid., para 34.

243 R Lines, 'From Equivalence of Standards to Equivalence of Objectives. The Entitlement of Prisoners to Standards Higher than those Outside Prisons', *International Journal of Prisoner Health* (2006), vol. 2, no. 4, pp. 269 - 280.

244 ECHR, *Pantea v. Romania*, no. 33343/96, Judgment of 3 September 2003, para 189; ECHR, Gelfmann v. France, para 50. op.cit

245 See European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment, 3rd General Report on the CPT's activities covering the period January 1 to December 31, 1992, para 31; ECHR, *Melnik v. Ukraine*, no. 72286/01, Judgment of March 28, 2006.

246 UN Office on Drugs and Crime/World Health Organization/UNAIDS, 'HIV/AIDS Prevention, Care, Treatment and Support in Prison Settings: A Framework for an Effective National Response' (2006) p. 19.

Discrimination

International human rights law protects every human being from discrimination based on various enumerated characteristics or membership of certain groups on a variety of explicitly enumerated grounds (e.g. race, colour, sex, religion, etc.). It also prohibits discrimination based on 'other status', which has been interpreted widely to include health status (including HIV status).[247] This prohibited form of discrimination is clearly of specific relevance to people who use drugs who are particularly vulnerable to HIV and other blood borne viruses as well as many other health-related problems.

Anti-discrimination legislation must address vulnerable groups. In relation to HIV prevention, for example, UNAIDS has stated that any laws enacted to prevent discrimination against people living with HIV 'should also protect groups made more vulnerable to HIV/AIDS due to the discrimination they face'.[248] This must include people who use drugs, who face significant barriers to HIV prevention and care due to their status as drug users (see below). The reality for people who use drugs in many countries, however, is a far cry from the legal protections enshrined in international human rights instruments.

Access to Antiretroviral Treatment

People who inject drugs represent the largest share of HIV cases in twenty nations in Asia and the former Soviet Union.[249] In many countries where people who use drugs are a significant share of those infected with HIV, their access to treatment is disproportionately low relative to other people living with HIV. In some jurisdictions, drug users have until recently been explicitly excluded from antiretroviral therapy solely based on their status as drug users. And even where such restrictions have been lifted, health care providers continue to deny antiretroviral treatment based on drug user status.

Every human being has the right to obtain life-saving health services without discrimination. *The International Covenant on Economic, Social and Cultural Rights* guarantees 'the right of everyone to the highest attainable standard of physical and mental health,' without discrimination on certain prohibited grounds (including physical or mental disability, health status, and any 'other status' that has 'the intention or the effect of nullifying or impairing the equal enjoyment or exercise of the right to health').[250]

Article 12 of the Covenant specifically obliges states to take all steps necessary for the prevention, treatment and control of epidemic diseases, and the 'creation of conditions which would assure to all medical service and medical attention in the event of sickness.' This includes 'the establishment of prevention and education programmes for behaviour-related health concerns such as sexually-transmitted diseases, in particular HIV/AIDS.'[251] Realisation of the highest attainable standard of health requires that states ensure equality of access to a system of health care and provide health information and services without discrimination, and protect confidential information.[252] It also requires states to take affirmative steps to promote health and to refrain from conduct that limits people's abilities to safeguard their health.[253] Laws and policies that 'are likely to result in . . . unnecessary morbidity and preventable mortality' constitute specific breaches of the obligation to respect the right to health.[254]

According to the Committee on Economic, Social and Cultural Rights, states have a 'special obligation . . . to prevent discrimination in the provision of health care and health services, especially with respect to core obligations of the right to health.'[255] These core obligations include ensuring non-discriminatory access to health facilities, especially for vulnerable or marginalized groups; providing essential drugs; ensuring equitable distribution of all health facilities, goods and services; adopting and implementing a national public health strategy and plan of action with clear benchmarks and deadlines; ensuring reproductive, maternal and child care; taking measures to prevent, treat and control epidemic and endemic diseases; and providing education and access to information for important health problems.[256] To justify the failure to meet at least minimum core obligations as based on a lack of available resources, a state party 'must demonstrate that every effort has been made to use all resources that are at its disposition in an effort to satisfy, as a matter of priority, those minimum obligations.'[257]

247 See for example, 'The protection of human rights in the context of human immune deficiency virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS)', UN Commission on Human Rights, Resolution 1999/49. For a discussion of human rights norms relating to discrimination based on HIV status and discrimination on the basis of drug dependence, see 'Legislating on Health and Human Rights: Model Law on Drug Use and HIV/AIDS, Module 7, Stigma and Discrimination', Canadian HIV/AIDS Legal Network, 2006.

248 UNAIDS/IPU, 'Handbook for Legislators on HIV/AIDS, Law and Human Rights', UNAIDS/99.48E, 1999, 127.

249 'Paradoxes in antiretroviral treatment', p. 246, op.cit.

250 ICESCR art 12(2)(c); Committee on Economic, Social and Cultural Rights, General Comment 14, 'The right to the highest attainable standard of health', UN Doc no E/C.12/2000/4, 11 August 2000, para 18.

251 ibid., para. 16.

252 ICESCR art 2(2) and ibid., paras 12, 16, 18, 19 , and note 8 (citing the right to information under article 19(2) of the ICCPR

253 ibid., paras 30-37.

254 ibid., para 50.

255 ibid., para 19.

256 ibid., paras 43 and 44; see also para 12.

257 Committee on Economic, Social and Cultural Rights, General Comment 3: 'The Nature of States Parties Obligations' (Art. 2)(1), UN Doc. E/1991/23., para. 10.

International experience has demonstrated that with adequate support, people who use drugs can adhere to antiretroviral treatment regimens and benefit from other HIV care at rates comparable to non-drug users.[258] Drawing on this experience, UN agencies – including WHO, UNODC, and UNAIDS – have identified important principles governing the delivery of HIV care and treatment to people who use drugs, and issued a number of guidance documents to facilitate optimal access and adherence to antiretroviral therapy to them.[259] Although national laws and HIV/AIDS policies may in principle recognise the right to non-discrimination in access to lifesaving antiretroviral therapy, in practice, drug users still face serious obstacles in obtaining equal access to necessary care.

A recent study by WHO Europe showed that in many countries, access to 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. According to WHO, 'In eastern European countries, where IDUs are the majority of reported HIV cases, relatively few IDUs receive HAART and, where they do, only few are current injectors when they initiate treatment.'[260] 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%. Furthermore, figures for active injectors are even lower. Limited data from seven reporting eastern European countries at the end of 2005 on the injecting status of those accessing HAART suggested that, on average, only 15% of reported people who inject drugs on HAART were current drug injectors when they initiated treatment.[261] According to WHO, the figures showed a clear inequity in access to treatment for HIV for injecting drug users.[262] 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% who had access to ART.[263]

BOX III: Denial of Access to Antiretroviral Treatment for Injecting Drug Users Living With HIV

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 2004, for example, the chief physician of St. Petersburg's City Health Committee reported that active drug users were not considered a good risk for AIDS treatment. 'Treatment is expensive, and it's not provided to active drug users. People have to sign a contract that they will continue to come every month; if they don't they know they can be taken out of the program. We know all of the people on treatment. We know who can be trusted and who not,' she said.[264] While express discrimination based on drug use status is now much less prevalent, numerous obstacles remain that impede equitable access to ART for people who use drugs.

As Russian law expressly prohibits the use of methadone and buprenorphine for treating drug dependence, this crucial adjunct for delivering AIDS treatment to people who use drugs and who are HIV-positive is unavailable.[265] Despite overwhelming evidence of its effectiveness in treating drug-dependent persons, as well as of its critical importance in HIV prevention and supporting adherence to antiretroviral therapy, top health and law enforcement officials as well as policymakers in Russia continue to vehemently oppose opioid substitution therapy, often on the basis of selective and inaccurate interpretation of research findings.[266]

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.[267] 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.'[268] Ukraine has taken some positive steps to improve access to antiretroviral therapy to drug users (including by taking steps to integrate buprenorphine and antiretroviral treatment programmes), but at this writing, methadone remains unavailable in Ukraine, and drug users continue to face barriers to care.[269]

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.[270] A report issued in 2007 found that while this policy change apparently benefited some people who use drugs, the government did not follow its policy change with awareness raising and training. Many healthcare providers either do not know or do not follow the revised guidelines, and therefore continue to deny antiretroviral treatment to people who need it based on their status as drug users, even if they are in methadone programs.[271]

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.

Registration often leads to discriminatory practices against people who use drugs. For example, 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. Research in **Russia** suggests that its registration system, which restricts the ability of drug users to obtain drivers' licenses and to hold certain jobs, violates the principle of non-discrimination, as the restrictions are disproportionate in nature and applied against certain groups of users.[272]

While the rationale behind these restrictions—public safety—may in principle appear to be legitimate, the restrictions are imposed selectively only on those who have to avail of free treatment at state clinics because they cannot afford to pay for treatment services. Whether a patient can pay for services is not a legitimate criterion on which to determine that private information about them should be retained on a registry and be used to restrict certain civil rights. Furthermore, the restrictions are disproportionate as they are imposed for a five-year period without any assessment whether there is a need to impose them on the individual in question or any periodic review to determine whether that need continues to exist.[273]

Moreover, some state drug dependence clinics in Russia appear to share information on patients who are on the state drug user registry with law enforcement and other government agencies. A 2006 survey conducted by the Penza Anti-AIDS Foundation of almost 1,000 drug users in ten Russian regions survey found that respondents in many of the regions surveyed believed that the clinics had shared information on them with others, mostly law enforcement agencies.[274]

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. A police superintendent in Chiang Mai – the site of many extrajudicial executions during the 2003 'war on drugs' – acknowledged in 2006 that his office maintained a list of those people suspected of using drugs. '[W]ho was likely to be a user, an addict, or a dealer . . . Each [district] must send their list to the provincial headquarters, which will then chase us up on whether those on the list have been arrested or not.' He further explained that they collected information about

258 See, for example, Matt Curtis, ed., 'Delivering HIV Care and Treatment for People Who Use Drugs: Lessons from Research and Practice' (New York: Open Society Institute, 2006), pp. 25-35.

259 The World Health Organization (WHO), the United Nations Office on Drugs and Crime (UNODC), and UNAIDS have identified important principles governing the delivery of HIV care and treatment to people who use drugs to facilitate their optimal access and adherence to antiretroviral therapy. See, e.g., WHO, UNAIDS, UNODC, 'Evidence for action on HIV/AIDS and Injecting Drug Use. Policy Brief: Antiretroviral Therapy and Injecting Drug Users', WHO/HIV/2005.06; WHO Regional Offices for South-East Asia and the Western Pacific, 'HIV/AIDS Care and Treatment for People Who Inject Drugs In Asia. A Guide to Essential Practice' (draft), December 2006; WHO, UNODC, UNAIDS, 'Substitution maintenance therapy in the management of opioid dependence and HIV/AIDS prevention: Position paper', 2004; World Health Organization Regional Office for Europe, 'HIV/AIDS Treatment and Care for Injecting Drug Users. Clinical Protocol for the WHO European Region', 2006, pp. 5-24.

260 Annemarie Bollerup, M Donoghoe, J Lazarus & SVMatic, 'Access to HAART for injecting drug users in the WHO European Region 2002–2005', summary available at http://www.euro.who.int/Document/SHA/ACCESS_TO_HART.pdf (Date of last access: 8 February 2008). For a more detailed analysis see Donoghoe et al, 'Access to HAART for injecting drug users in the WHO Europe Region 2002-2004', *International Journal of Drug Policy* 18 (2007) pp. 271-280.

261 Bollerup et al, 2005, op.cit.

262 ibid.

263 Aceijas et al 'Antiretroviral treatment for injecting drug users in developing and transitional countries one year before the end of the 'Treating 3 million by 2005. Making it happen. The WHO Strategy (3x5)' *Addiction*, 101(9), pp. 1246-1253.

264 'Lessons not Learned' p. 45, op.cit.

265 Federal Act on Narcotic and Psychotropic Substances, art 55(2).

266 See discussion in Human Rights Watch, 'Rehabilitation Required: Russia's Human Rights Obligation to Provide Evidence-based Drug Dependence Treatment', *A Human Rights Watch Report*, November 2007, pp. 47-51 (Hereafter Rehabilitation Required).

267 See 'Rhetoric and Risk' p.17, op.cit.

268 Global Fund to Fight AIDS, Tuberculosis and Malaria, 'Grant Performance Report', June 2005, p. 24. According to the International HIV/AIDS Alliance, 1,116 (of 2,104) people receiving ARVs through its programme were drug users, but the data did not indicate how many of them were active drug users.

269 Restrictions on methadone import were lifted in December 2007, which will allow for methadone-based substitution maintenance therapy programmes to begin in Ukraine and for considerable expansion in delivery of this service.

270 The guidelines stated, '[P]atient who still has risk behaviours, such as drug addiction, should rehabilitate until rehabilitated first.' Ministry of Public Health, Thailand, 'Practical Approach to developing the service system and monitoring the results of treatment for people living with HIV/AIDS with ARV therapy in Thailand', 2002 (National ARV Treatment Guidelines), November 2002, p. 16 (in Thai).

271 'Deadly Denial' pp. 26-32, op.cit.

272 The types of jobs that people registered as being dependent on drugs cannot perform include, among others, those that involve work at certain power stations, with any explosive substances or in industries that are high risk for explosions or fire, work as guards who carry arms, driving a car, or work linked to various aspects of the train system. Ukraine has similar registration requirements and restrictions on drivers' licenses and occupations. See 'Rhetoric and Risk', p. 31, op.cit.

273 'Rehabilitation Required' pp. 56-58, op.cit.

274 ibid., p. 26

drug users from both public and private hospitals.[275] In **Malaysia**, all patients on government methadone programmes and those sent to compulsory treatment must be registered. In Viet Nam, the names are kept by community focal points and passed on to the Department of Social Evils and the National Drugs Committee.[276]

Drug user registries can greatly increase the chances of disclosure to law enforcement officials, and, as noted above, fear of punishment can deter those in need of vital healthcare away from available services. For example, aside from the effects on HIV prevention efforts which have been outlined above, studies have also shown that fear of arrest may even deter people from calling the emergency services in cases of potentially fatal overdoses.[277] Furthermore, aside from resulting in discriminatory practices, the routine sharing of medical information of drug users violates the acceptability component of the right to health,[278] and the right to privacy protected under the *European Convention on Human Rights*[279] and the *International Covenant on Civil and Political Rights*[280].

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. They are socially excluded and marginalised. In countries across the world, supply-

BOX IV: Denial of Access to Essential Services

Discrimination as a barrier to access to antiretroviral treatment has already been highlighted in detail above, but as also noted above in relation to employment and obtaining drivers' licenses, drug user status and disclosure of that status can affect access to many other services, violating, in each case, the right to be free from discrimination. In many cases, such discriminatory practices stem from stigma and prejudicial attitudes directed towards people who use drugs.

In the **United Kingdom**, for example, active injecting drug users are often refused treatment for hepatitis C virus (HCV).[281] Despite official guidance in 2007 that anyone with HCV should be treated,[282] many consultants will test, but will not treat active injectors. The result is that active injectors are tested to monitor HCV prevalence, but in many cases treatment is not offered because of their drug use, leaving patients with a diagnosis and no prospect of assistance. The basis for this is the assumption that people who use drugs will not adhere to treatment and that they will become reinfected following treatment. In other words, it is not deemed cost effective to treat them. The evidence, however, does not support these concerns. People who use drugs have been found to adhere well to treatment and are, in fact, unlikely to become reinfected if they clear the virus.[283]

Similarly, 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, regardless of their HIV status. 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'.[284] An outreach worker noted the problem of stigmatising criminalisation of people who use drugs, stating that medical workers 'don't look at drug users as ill people, but like criminals, like bandits'[285]. Human Rights Watch also interviewed a number of active drug users who had treated themselves for serious abscesses caused by injecting after having been refused medical treatment.[286]

Following her recent visit to **Sweden**, the Special Rapporteur on violence against women, Yakin Ertürk, raised a number of concerns about the situation of women who use drugs and are involved in sex work and at risk from domestic violence in Sweden. Despite some improvements in recent years, she noted that the Swedish government had largely neglected to address the situation of women who use drugs and are involved in sex work. As a result their access to support and advice was therefore greatly affected, despite the fact that due to their drug use they were more at risk of violence and more likely to engage in risky sexual activity to fund their drug use.[287] The Special Rapporteur's findings relating to domestic violence, however, serve as one of the most striking examples of the effect of drug user status on access to services in the country with one of the highest standards of living in the world. She noted with concern that 'women with severe alcohol or drug problems are usually not given access to existing shelters if they face violence. Unless they agree to enter an addiction rehabilitation programme (and actually find a place), they face a protection gap.'[288] There are few clearer examples of the prominence that drug control has taken and the extent to which the most basic of services and the most fundamental of human rights may be denied solely on the basis of drug use.

side and punishment-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 is the positive obligation to identify those groups and individuals in need of special care and assistance to ensure that their rights are guaranteed.[289] The Human Rights Committee, almost twenty years ago, noted that 'the principle of equality sometimes requires states parties to take affirmative action in order to diminish or eliminate conditions which cause or help to perpetuate discrimination prohibited by the Covenant. For example, in a country where the general conditions of a certain part of the population prevent or impair their enjoyment of human rights, the state should take specific action to correct those conditions'.[290]

In the context of drug control this requires a more human and health based approach in order to address existing vulnerabilities to problematic drug use and involvement in drug related crime. The alternative development approach adopted in relation to crop eradication by the UNODC reflects this obligation in connecting illicit crop growing to underlying developmental issues and poverty. Indeed, this is the only aspect of drug control to be specifically connected to human rights anywhere in the three drug conventions.[291] Unfortunately, national drug control efforts, driven in large part by international obligations more often stigmatise people who use drugs and focus overwhelmingly on criminalisation. Such approaches, rather than identifying and assisting those in need, may well help to 'perpetuate' those conditions that lead to discrimination.

BOX V: Drug Policy and Racial Discrimination in the United States

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. This was despite the fact that federal surveys and other data showed that this racial disparity bore little relation to racial differences in drug offending. There are, for example, five times more white drug users in the United States than black.[292] In New York, 94% of those sentenced for drug offences in the state are African-American or Hispanic.[293] As noted by Human Rights Watch 'but for the war on drugs, the extent of black incarceration would be significantly lower'. [294]

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. Within favela communities it is common for children and young people to work for family income. But 'employment opportunities for children and youth have diminished at the same time as drug trafficking as a means for financial advancement has become more accessible'.[295] As noted by one favela resident, '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

275 'Deadly Denial' p. 21. op.cit.

276 'Paradoxes in antiretroviral treatment', 249, op.cit.

277 A Kral & R Bluthenthal (2004). 'The impact of police practices on the health of IDUs in the San Francisco Bay area' Abstract No. 1140. Presented at the 15th International Conference on the Reduction of Drug-Related Harm, Melbourne, Australia, 20–24 April 2004.

278 Committee on Economic, Social and Cultural Rights, General Comment No. 14, para 12(b), op.cit.

279 European Convention on the Protection of Human Rights and Fundamental Freedoms, art 8, ETS 5), 213 U.N.T.S. 222, *entered into force* Sept. 3, 1953, as amended by Protocols Nos 3, 5, and 8 which *entered into force* on 21 September 1970, 20 December 1971 and 1 January 1990 respectively.

280 ICCPR art 17.

281 Hepatitis C is a blood-borne virus, often referred to as a silent killer. It slowly destroys the liver, resulting, eventually, in death from cirrhosis. With treatment it can be cleared in 60% of cases.

282 'NICE technology appraisal guidance 106, Peginterferon alfa and ribavirin for the treatment of mild chronic hepatitis C', National Institute for Health and Clinical Excellence (NICE), November 2007, para 4.3.12, http://www.nice.org.uk/nicemedia/pdf/TA106guidance.doc (Date of last access: 8 February 2008).

283 Dr Graham Foster, 'Hepatitis C, Casting a Long Shadow', Presentation given at the 2007 Release conference, available at http://www.rcgp.org.uk/docs/drug_Treatment%20for%20Hepatitis%20-%20Dr%20Graham%20Foster.ppt#288,35 (Date of last access: 14 February 2008).

284 'Rhetoric and Risk' p. 48, op.cit.

285 ibid., p. 49

286 ibid.

287 'Report of the Special Rapporteur on violence against women, its causes and consequences, Yakin Ertürk, Mission to Sweden', 6 February 2007, UN Doc A/HRC/4/34/Add.3, paras 44 & 45.

288 ibid., para 62

289 This formulation has been most clearly stated by the Committee on the Rights of the Child. See for example, General Comment No. 5, para 12, op.cit.

290 Human Rights Committee, General Comment No. 18, 'Non-Discrimination', CCPR General Comment No. 18, 10 November 1989. http://www.unhchr.ch/tbs/doc.nsf/(Symbol)/3888b0541f8501c9c12563ed004b8d0e?Opendocument (Date of last access: 20 February 2008).

291 1988 Convention art 14(2).

292 Human Rights Watch, 'Punishment and Prejudice: Racial Disparities in the War on Drugs', A Human Rights Watch Report, Vol 12, No 2(G) May 2000, available at http://www.hrw.org/reports/2000/usa/ (Date of last access: 13 February 2008). (Hereafter Punishment and Prejudice). Human rights Watch is currently updating this study.

293 Human Rights Watch, 'Reforming the Rockefeller Drug Laws', http://www.hrw.org/campaigns/drugs/index.htm (Date of last access: 13 February 2008).

294 'Punishment and Prejudice' op.cit.

295 'Children of the Drug Trade', p. 121, op.cit.

view they think that trafficking is the easiest option'.[296] Moreover, the majority of violent gun battles between police and drug gangs are played out on the streets of the overcrowded favelas with the main victims being some of the country's poorest residents.

It is not suggested that drug traffickers bear no responsibility for recruiting children and young people, for using violent measures such as torture and execution or for engaging in open gunfire with police or, indeed, among themselves.[297] Nonetheless, the state has a responsibility to take measures to protect the human rights of vulnerable communities as a matter of priority and to address the root causes of problematic drug use and involvement in trafficking. Instead, repressive law enforcement and violent reprisals played out against entire communities appear to be measures of first report.

Justifiable Violations? Human rights restrictions and the principle of proportionality

It is well known that very few human rights are absolute.[298] Most rights may be restricted or lawfully infringed, but subject to very specific justifications and limitations. 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.[299]

It could be easily argued that drug control measures pursue the legitimate aim of protecting public order and public health. The question, therefore, is whether the measures adopted are proportionate to that aim. This paper has described mass crop eradication campaigns that ignore cultural uses of those crops, damage food crops and adversely affect the health of local communities. It has described forced treatment programmes which amount to detention without trial. And it has highlighted the denial of vital services including HIV prevention and care solely on the basis of status as a drug user. Even if such measures were effective in controlling illegal drug supply and demand, this would not justify the violations involved.[300]

Proportionality of sentence – that the penalty shall fit the crime – is a central tenet of criminal justice. In many cases, sentences for drug-related crimes far outweigh the seriousness of the crime. In the **United States**, three strikes legislation in some states can result in life sentences for petty and non-violent drug crimes.[301] In many countries, as detailed above, people are sentenced to death and executed for drug offences, sometimes for possession of relatively small amounts of illicit drugs.[302] In some countries, such sentences are mandatory. Such penalties are entirely disproportionate to the crimes involved and therefore represent unlawful violations of the rights of those sentenced. In more general terms, legislation imposing mandatory minimum sentences for drug offences violates the basic principle of proportionality by preventing courts from determining the penalty appropriate in the circumstances of an individual case, and can also result in further discrimination in the application of drug offences, on grounds such as race and sex, as has been demonstrated by the experience in the U.S.[303]

Research has demonstrated the ineffectiveness of mandatory minimum sentencing approaches in reducing drug consumption and drug-related crime.[304] 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.[305] The question must be asked – if a measure fails to achieve its 'legitimate aim' can it ever be considered 'necessary' to achieve that aim and therefore "proportionate"?

296 ibid., p. 120. For a more in depth discussion see ibid., pp. 123-138.

297 For a discussion of some of the punishments and executions carried out by drug gangs in the favelas see 'Children of the Drug Trade', pp. 65-69, op.cit.

298 Freedom from torture is a notable exception.

299 See *Handyside v UK*, Eur Ct HR, App No. 5493/72 7 December 1976, and *Observer and Guardian v UK*, Eur Ct HR, App No. 13585/88, 26 November 1991.

300 As noted by the European Court of Human Rights in relation to judicial corporal punishment, "[I]t must be pointed out that a punishment does not lose its degrading character just because it is believed to be, or actually is, an effective deterrent or aid to crime control. Above all, as the Court must emphasise, it is never permissible to have recourse to punishments which are contrary to Article 3 (art. 3), whatever their deterrent effect may be." *Tyrer v United Kingdom* (1978) 2 EHRR 1, para 31

301 See for example, Justice Policy Institute, 'Still Striking Out: Ten years of California's three strikes policy', 2004, http://www.justicepolicy.org/images/upload/04-03_REP_CAStillStrikingOut_AC.pdf; and Justice Policy Institute, 'Three Strikes and You're Out: An examination of the impact of 3-strike laws 10 years after their enactment', 2004, http://www.soros.org/initiatives/justice/articles_publications/publications/threestrikes_20040923/three_strikes.pdf (Date of last access: 20 February 2008).

302 The right to life may be infringed in the context of the death penalty, but as noted above, only in very specific circumstances. The death penalty for drugs does not meet the required threshold of 'most serious crimes'. For a discussion of this issue see Rick Lines 'The Death Penalty for Drug Offences: A Violation of International Human Rights Law' International Harm Reduction Association, 2007. http://www.ihra.net/uploads/downloads/NewsItems/DeathPenaltyforDrugOffences.pdf (Date of last access: 21 February 2008).

303 e.g., see: American Civil Liberties Union, Break the Chains, and the Brennan Center at NYU School of Law. 'Caught in the net: The impact of drug policies on women and families'. New York, 2006, p. i.

304 e.g., T Gabor and N Crutcher 'Manadatory minimum penalties: Their effects on crime, sentencing disparities, and justice system expenditures'. Ottawa: Justice Canada (Research and Statistics Division), January 2002.

305 Beckley Foundation Drug Policy Programme, 'Incarceration of Drug Offenders: Costs and impacts', 2005, http://www.beckleyfoundation.org/pdf/paper_07.pdf (Date of last access: 20 February 2008).

PART III

Human Rights Violations, Or A Rights-Based Approach? The Need For Greater System-Wide Cohesion

We will not enjoy development without security, we will not enjoy security without development, and we will not enjoy either without respect for human rights [306]

We resolve…to support the further mainstreaming of human rights throughout the United Nations system [307]

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.

It has been argued that there are significant benefits to using human rights language as a 'normative counterweight' to the prohibitionist and punitive drug control paradigm.[308] This is not to imply equivalence between the two systems when assessing human rights obligations in the context of drug control. 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 such as those detailed above are to be prevented, is a human rights-based approach to drug policy and 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

Political leadership is essential if human rights are to be fully protected. As a UN entity made up of member states, the CND is obligated to further the purposes of the United Nations. As the governing body of the UNDCP, it also has the responsibility to operationalise the numerous directives of the General Assembly requiring that drug control must be carried out in conformity with the Charter of the UN and with international human rights law.[309] The member states of the CND must therefore 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.

A barrier to such leadership from CND, however, may be that, aside from the issue of scheduling, the Commission never puts any issue to a vote, no matter how important or divisive, including questions of human rights protections and harm reduction interventions to prevent HIV transmission. This means, in effect, that individual member states can veto human rights language[310]. While UN political bodies at various levels strive for consensus in their working practices, and many resolutions are adopted without a vote, the vast majority of these commissions routinely resolve contentious issues by recourse to voting procedures. The CND is empowered to make decisions by majority vote, as specified in its first resolution on its rules of procedure[311], and as required by the ECOSOC rules of procedure for functional commissions.[312] Far from being an official requirement, therefore, the Commission's focus on consensus is one of custom, developed by Vienna diplomats over the years. Therefore, the required leadership from CND may have to emanate from individual member states willing to break with convention and call a vote for progress on human rights.

306 'In Larger Freedom', para 17, op.cit.

307 2005 World Summit Outcome, UNGA Res 60/1 UN Doc A/RES/60/1 24 October 2005, para 126.

308 Elliott et al, 'Harm Reduction, HIV/AIDS, and the Human Rights Challenge to Global Drug Control Policy', op.cit.

309 op.cit.

310 See above, Part I, 'Human rights, drug control and UN governance'.

311 CND Dec.1(1) November/December 1946 art 6 'Voting: Decisions of the Commission shall require a majority of the members present and voting'.

312 op.cit.

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.[313]

A number of specific elements are essential to this approach:

- **Mainstreaming of human rights throughout UNODC organisational strategies**

The UNODC has recently presented its strategy for 2008-2011.[314] While the strategy rightly notes the need for recognition of 'relevant international conventions' and 'standards', relating to issues such as prisons, juvenile justice and HIV prevention among injecting drug users,[315] it makes no specific mention of human rights. Though human rights norms must certainly be included in 'relevant international conventions', this is an unfortunate oversight, particularly given the central position held by human rights in the UN system and the UN system-wide celebration of the Universal Declaration of Human Rights taking place throughout 2008.

A central objective of the strategy is 'To promote, at the request of member states, effective responses to crime, drugs and terrorism by facilitating the implementation of relevant international legal instruments'.[316] This must include respect for fundamental human rights as an indispensable component, and, indeed, the guiding principle, of any 'effective response. The strategy should therefore be revised to make specific reference to UNODC's human rights obligations as a UN agency and the need to support the promotion and protection of fundamental human rights throughout its own work and at national level in the formulation and implementation of drug control policies.

- **Human Rights Impact Assessments (HRIA) for all UNODC programmes**

The CND should adopt a resolution calling on UNODC to develop human rights impact assessments for all current and future programmes. According the UN Special Rapporteur on the Right to health, Professor Paul Hunt, 'Human rights impact assessment is the process of predicting the potential consequences of a proposed policy, programme or project on the enjoyment of human rights. The objective of the assessment is to inform decision makers and the people likely to be affected so that they can improve the proposal to reduce potential negative effects and increase positive ones'.[317] Human rights impact assessments are a key element of a human rights-based approach, and are a vital pre-emptive measure to ensure not only that activities or programmes do not contribute to human rights violations, but that they are geared towards the advancement of human rights protections. The Office of the High Commissioner for Human Rights has an important role to play in this regard, having developed human rights impact assessments for businesses in co-operation with business networks and the World Bank Groups as a part of the United Nations Global Compact.[318]

- **Development of human rights indicators for UNODC activities**

While impact assessments are key to project planning and development, indicators are crucial for monitoring and assessment. Therefore the ability to measure human rights achievements and violations is an essential component of a human rights-based approach. To this end, specific human rights indicators should be developed to measure UNODC's success or failure on its human rights obligations. There are considerable resources that may be utilised to develop such indicators, including the recent work of the Special Rapporteur on the Right to the Highest Attainable Standard of Health[319] and the human rights indicators developed by UNDP.[320] At each session of the CND the Executive Director of UNODC should report on the human rights impacts of its work.

- **Rejection of stigmatising language**

Prejudice and social exclusion are some of the greatest barriers facing people who use drugs. Negative attitudes and stereotypes about people who use drugs can result in many of the repressive

313 'UN Statement of Common Understanding: The Human Rights-Based Approach', Developed at the Inter-Agency Workshop on a human rights-based approach in the context of UN reform, 3 to 5 May 2003, available at http://www.unicef.org/sowc04/files/AnnexB.pdf (Date of last access: 11 January 2008).

314 UNODC, Medium Term Strategy, 2008-2011 UN Doc No E/CN.7/2007/14–E/CN.15/2007/5, 9 February 2007, available at http://www.unodc.org/unodc/en/frontpage/unodc-strategy.html (Date of last access: 18 February 2008).

315 ibid., see, for example, paras 3.3.1., 3.6.1. and 3.7.1.

316 ibid., p.5.

317 Report of the Special Rapporteur on the Right to the Highest Attainable Standard of Physical and Mental Health, Professor Paul Hunt, Un Doc No A/62/214, 8 August 2007, para 37.

318 The Global Compact, International Finance Corporation and International Business Leaders Forum 'Guide to human rights assessment and management', June 2007.

319 Report of the Special Rapporteur on the Right to the Highest Attainable Standard of Physical and Mental Health, Professor Paul Hunt, 3 March 2006, UN Doc E/CN.4/2006/48.

320 UNDP, 'Indicators for Human Rights-Based Approaches to Development in UNDP Programming: A Users' Guide', March 2006.

and discriminatory practices highlighted in this paper. The UN has a central role to play to in this regard. Unfortunately, much of the language in relation to people who use drugs is far from favourable, painting them as 'drug abusers' - deviants, outside of normal society. The International Narcotics Control Board has often used particularly problematic and unhelpful language. In its 2002 Annual Report, for example, the Board stated that 'The sight of unkempt drug abusers on street corners and in train stations, begging for money to finance their drug habits, cannot be ignored by responsible Governments. States have a moral and legal responsibility to protect drug abusers from further self-destruction'.[321] The UN should take the lead in adopting language that recognises that people who use drugs are often those in need of care and assistance to ensure that their rights are guaranteed, and people whose opinions and input is vital if progress on problematic drug use and drug related harm is to be achieved.

- **Greater joint planning and co-working between the UNODC and the OHCHR**

The UNODC has a long history of collaboration with UN agencies, funds and offices on a wide range of issues. It has, for example, co-signed joint policy papers on needle exchange and opioid substitution treatment with the World Health Organisation and UNAIDS,[322] of which it has been a co-sponsor for almost ten years. It works closely with UNDP in its alternative development programmes and in 2007 it launched UN.GIFT, the 'Global Initiative to End Human Trafficking', managed in partnership with the International Labour Organization (ILO); the International Organization for Migration (IOM); the United Nations Children's Fund (UNICEF); the United Nations High Commissioner for Human Rights (UNHCHR); and the Organization for Security and Co-operation in Europe (OSCE).[323]

Unfortunately, there have been no such collaborations in relation to drug control or HIV prevention with the OHCHR.[324] According to its 2008-2009 Strategic Management Plan, the Office of the High Commissioner for Human Rights 'will work to advance the integration of human rights and their gender dimension into the policies, programmes and activities of the entire UN system, particularly at the country level. During 2008-2009, OHCHR will continue to provide expertise and support in key cross-cutting themes in human rights: equality and non-discrimination; indigenous peoples'[325] and minority rights, development; economic, social and cultural rights; rule of law, transitional justice and democracy; human rights-based approaches to peace and security and humanitarian work; human rights methodologies and human rights education'. Almost every single one of these themes has been highlighted above as being potentially affected by drug control.

While some specific avenues for collaboration between the UNODC and the OHCHR have been identified in this section, closer strategic planning generally is essential 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 caused by drug control efforts by the UN human rights treaty bodies, Special Procedures and the Human Rights Council

Human rights-based programmes within the UN system must be guided by the recommendations of the organisation's human rights entities. Unfortunately, with notable exceptions,[326] there is a dearth of jurisprudence and policy guidance stemming from these bodies in the area of drug control. Further guidelines are badly required from the UN human rights system to ensure that human rights requirements in the context of drug control are fully understood.

As the main political entity with responsibility for human rights, the Human Rights Council must play a central role. The Council 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, and 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.[327]

4. Donor Accountability

The importance of donors in promoting a human rights-based approach should not be underestimated. The current law enforcement approach is driven in large part by a handful of powerful donor states and the reliance of the UNODC on earmarked funds. Individual states have legal obligations to protect and promote human rights resulting from their ratification of human rights treaties, as well as their overarching obligations under the UN Charter. Donor

321 INCB, 'Report of the International Narcotics Control Board for 2002', Foreword.

322 WHO, UNAIDS and UNODC 'Evidence for Action Policy Brief: The provision of sterile injecting equipment to reduce HIV transmission', op.cit.; and WHO/UNODC/UNAIDS position paper, 'Substitution maintenance therapy in the management of opioid dependence and HIV/AIDS prevention', 2004, http://www.unodc.org/docs/treatment/Brochure_E.pdf (Date of last access: 21 February 2008).

323 http://www.ungift.org/ (Date of last access: 20 February 2008).

324 UNODC is on the inter-agency team of the UN Global Compact, in collaboration with six UN bodies, including OHCHR. See http://www.unglobalcompact.org/AboutTheGC/stages_of_development.html (Date of last access: 20 February 2008).

325 OHCHR, High Commissioner's Strategic Management Plan 2008-2009, http://www.ohchr.org/Documents/Press/SMP2008-2009.pdf (Date of last access: 18 February 2008).

326 See various commentaries from the human rights treaty bodies and Special Rapporteurs noted in Part II.

327 'Regime Change?: Drug Control, Users' Human Rights and Harm Reduction in the Age of AIDS', Draft background paper for *Human Rights at the Margins: HIV/AIDS*, Prisoners, Drug Users, and Law, Canadian HIV/AIDS Legal Network, 2004.

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 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

ECOSOC, the CND's governing body, requires that its functional commissions engage with civil society, in recognition of the important role that NGOs, civil society organisations and affected communities have in achieving their various mandates.[328] Civil society engagement at CND, however, has been minimal and tokenistic at best, with NGOs granted only observers status with very limited opportunity to make representations. In practice, any member state may request that NGO representatives leave the room during discussions. The limited engagement of CND with civil society runs contrary to the spirit of its own resolution 49/2[329] as well as ECOSOC resolution 1996/31.[330] It also results in stifling debate, reducing member state accountability on drug policy and human rights and ultimately the production of sub-optimal recommendations and policies from CND.

Arguably, however, civil society engagement at the CND has, in some ways, improved. The 'Beyond 2008' process, co-ordinated by the Vienna NGO Committee, and aimed at improving civil society involvement in the upcoming General Assembly Special Session on drugs, is an important example.[331] But there is significant scope for improvement in the day to day working of the CND and in the participation of NGOs in its policy formation. There are many best practice examples of civil society engagement in the UN system to which CND may look to improve its working methods, including, for example, the Commission on the Status of Women, a sister functional commission, which has developed extensive NGO participation guidelines.[332] CND should develop similar guidelines

6. Reform of the INCB

The INCB has claimed, incorrectly, that it is 'unique in international relations',[333] and has used this position to justify working methods that are out of step with the rest of the UN system, including the similarly constituted human rights treaty bodies.[334] All meetings are conducted in secret. None of its letters to governments nor are any minutes of its meetings are published. As noted above, the Board expressly refuses to engage with civil society and has also publicly stated that it will not discuss human rights, despite the specific mention of human rights protection in the 1988 drug convention and the prominence of human rights in the *Charter of the United Nations*.

It is clear that the INCB's 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. It has also become apparent that its views and recommendations have fallen out of step with UN policy and best practice in issues of global importance such as HIV prevention. 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.

A number of recent publications have set out specific recommendations for reform of the INCB, including more transparent operation and opening up its processes to civil society engagement; greater focus on availability and quality of treatment for chemical dependence; increased HIV expertise on the Board; less restrictive interpretation of the drug control treaties; independent review of the Board for greater accountability; and greater understanding and acceptance of broader UN aims.[335]

328 ECOSOC Res 1996/31 'Consultative relationship between the United Nations and non-governmental organizations'.

329 CND Resolution 49/2 'Recognizing the contribution of civil society in global efforts to address the drug problem in the context of reporting on the goals and targets for 2008 set by the General Assembly at its twentieth special session'.

330 op.cit.

331 See http://www.vngoc.org/details.php?id_cat=8&id_cnt=27 (Date of last access: 7 February 2008).

332 See http://www.un.org/womenwatch/daw/csw/csw52/NGO.html (Date of last access: 7 February 2008).

333 Mr Koli Kouame, Secretary of the INCB, March 2007, op.cit.

334 See Damon Barrett Unique in International Relations? A Comparison of the International Narcotics Control Board and the UN Human Rights Treaty Bodies', International Harm Reduction Association, 2008 http://www.ihra.net/uploads/downloads/NewsItems/Barrett-UniqueinInternationalRelations.pdf (Date of last access: 18 February 2008) (Hereafter Unique in International Relations).

335 See 'Closed to Reason', pp. 20 & 21 and 'Unique in International Relations', pp. 40 & 41, op.cit.; see also D Bewley-Taylor & M Trace, The International Narcotics Control Board: Watchdog or Guardian of the UN Drug Control Conventions? Beckley Foundation Drug Policy Programme, Report No. 7, February 2007, and International Drug Policy Consortium, 'INCB: Current tensions and options for reform', 2008, forthcoming.

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 all 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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