

Abstract

The global HIV/AIDS pandemic, and the role of unsafe drug injection as one of its principal drivers, have added to the list of harms associated with unsafe drug use. HIV/AIDS has highlighted ways in which prohibitionist drug policy causes or contributes to such harms and focused attention on the international regime of illicit drug control. At the same time, HIV/AIDS has catalyzed the “health and human rights movement” to articulate legal and policy responses that both represent sound public health policy and fulfill human rights obligations recognized in international law; this necessarily includes scrutinizing the interpretation and implementation of the UN drug control conventions. This article brings together public health evidence and legal analysis as a contribution toward changing the global drug control regime to a more health-friendly, human rights-based system.

La pandémie mondiale VIH/SIDA, et le rôle des injections dangereuses de drogues comme étant un de ses moteurs principaux, a rallongé la liste des dangers associés aux injections dangereuses et insalubres de drogues. Le VIH/SIDA a mis en évidence comment la politique d’interdiction de la drogue cause ces dangers, ou y contribue, et a concentré l’attention sur le régime international de contrôle des drogues illégales. En même temps, le VIH/SIDA a servi de catalyseur au “mouvement de la santé et des droits de l’homme” pour mettre en circulation des réponses juridiques et politiques qui harmoniseraient à la fois une saine politique de santé publique et le respect des droits de l’homme reconnus par les traités internationaux; elles comprennent nécessairement l’examen de l’interprétation et de la mise en œuvre des traités de contrôle des drogues signés dans le cadre de l’ONU. Cet article rassemble des preuves en matière de santé publique et d’analyse juridique, pour contribuer à faire du régime international de contrôle des drogues un système davantage orienté vers la santé et les droits de l’homme.

La pandemia VIH/SIDA mundial, y el papel que juega la inyección arriesgada de drogas como uno de los factores principales que la impulsa, han sido añadidos a la lista de daños que conlleva el uso arriesgado de drogas. El VIH/SIDA ha hecho resaltar formas en las que una política de drogas prohibicionista ocasiona o aporta a tales daños y ha enfocado la atención en el régimen internacional de control de drogas ilícitas. A la misma vez, el VIH/SIDA ha acelerado el “movimiento de salud y derechos humanos” en cuanto a la presentación de respuestas de política y legales que representa una política de salud pública sensata a la vez que cumplen obligaciones de derechos humanos reconocidas en el derecho internacional. Estas respuestas incluyen necesariamente un análisis minucioso de la interpretación y ejecución de las convenciones de control de drogas de las Naciones Unidas. Este artículo junta las pruebas de salud pública y el análisis legal como una aportación hacia un cambio del régimen de control de drogas mundial a un sistema más amigable para la salud, basado en los derechos humanos.

HARM REDUCTION, HIV/AIDS, AND THE HUMAN RIGHTS CHALLENGE TO GLOBAL DRUG CONTROL POLICY

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The global HIV/AIDS pandemic has added to the list of harms associated with unsafe drug use and provided yet further evidence that the dominant, prohibitionist approach to illicit drugs is not only ineffective but also counter-productive. Embodying this approach, international drug control treaties cast a chill over — or in some cases, may prohibit, *de jure* or *de facto* — implementation of measures proven effective in reducing the spread of HIV. Furthermore, a prohibitionist paradigm engenders policies and practices that inhibit drug users' access to care, treatment, and support, be it for HIV disease, addiction, overdose, or other health concerns.

Consequently, the HIV/AIDS pandemic has intensified debate over the norms and institutions of the global drug control regime. In part because of the increasingly apparent devastation of injection drug use and associated spread of HIV, pressure is mounting for drug policy reform at the international as well as domestic level. AIDS has upped the

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ante; the sheer magnitude of the epidemic driven by unsafe drug use has meant greater pressure to confront issues that governments would often rather ignore. It is increasingly evident that a commitment to harm reduction — defined broadly as “policies and programs which attempt primarily to reduce the adverse health, social and economic consequences of mood altering substances to individual drug users, their families and their communities” — must entail some degree of reform of the dominant prohibitionist approach.^{1,2} Simultaneously, the emergence of HIV/AIDS has catalyzed a movement of researchers and activists articulating the multi-dimensional, multi-directional relationship between health and human rights. Given that unsafe drug use, particularly by injection, is now one of the major factors fueling the global epidemic, it is only natural that the legal regime that affects drug use(rs) comes under human rights scrutiny.

A commitment to the human rights of drug users has marked the thinking and advocacy of many people concerned with harm reduction from the outset, and the principles, objectives, and initiatives that fall under the broad rubric of “harm reduction” can be characterized as reflecting or advancing human rights. Harm reductionists, therefore, in effect, are human rights advocates, contributing to a larger effort aimed at securing universal respect for, and observance of, fundamental human rights. Yet it is only in recent years that the language of human rights has begun to inform discussions about drug policy reform in international and inter-governmental fora beyond the circles of harm reduction proponents and/or human rights experts.³

There may be strategic reasons, in any given instance, to focus on either the “public health” rationale or a “human rights” argument for a specific reform in order to sway decision-makers in a particular direction. Combining the two approaches, however, may strengthen such a case: public health evidence can support principled legal arguments with a sound evidentiary basis, and the principles of human rights law strengthen statistical or other data with the normative claim that states have an ethical and legal obligation to act upon that evidence. We suggest that joining human rights law with public health evidence can help shift global drug control

policy away from the current, failed emphasis on prohibition to a more rational, health-promoting framework that is both pragmatic and principled. As a contribution to this collective endeavor of “regime change,” this article:⁴

- reviews briefly the global extent of injection drug use and the linked HIV/AIDS epidemic and the impact of prohibition and harm reduction on health and human rights, focusing on HIV/AIDS-related effects;
- outlines the basic elements of the international legal regime of illicit drug control;
- considers some of the conceptual and programmatic links between harm reduction and human rights as recognized in international law; and
- discusses strategies for reforming global drug control policy to reflect a more human rights-based approach that facilitates harm reduction.

Injection Drug Use and HIV/AIDS: Global Health Challenges

Recent estimates suggest that there are over 13 million people who inject illicit drugs in the world today, the majority of whom are from developing countries.⁵ Injection drug use was first documented in North America, Australia, and Western Europe well before HIV/AIDS was first discovered, but evidence of the emergence and rapid diffusion of injection drug use has recently been documented in Eastern Europe, the former Soviet Union, South East Asia, China, India, the Middle East, and West Africa.⁶ HIV prevalence higher than 20% among persons who inject drugs has been reported for at least 1 site in 25 countries and territories, from several different regions of the world.⁷

Injection drug use is a key risk factor for HIV infection, given the high-risk behavior of sharing injection equipment.⁸ Of the 136 countries that reported injection drug use in 2003, 93 also reported HIV infection among users.⁹ In Eastern Europe and the former Soviet Union, regions with two of the fastest growing HIV epidemics, injection drug use accounts for the majority of new infections.¹⁰ In other countries, such as Thailand, high HIV incidence persists in this

population.¹¹ Currently, injection drug use is estimated to account for 10% of HIV infections globally, although this proportion is likely increasing in light of the dual epidemics of injection drug use and HIV in Eastern Europe, the former Soviet Union, and Asia.¹² Experience demonstrates that HIV can spread rapidly once established within communities of drug users.¹³ Other health-related harms among persons who inject drugs include high rates of hepatitis C infection, bacterial infections, multi-drug-resistant tuberculosis, fatal and non-fatal overdoses, and high violence and suicide rates.¹⁴

Overall, the evidence suggests that while drug users generally do not enjoy adequate access to highly active anti-retroviral therapy (HAART), the challenges of access and adherence to treatment regimens can be overcome with appropriate support, including the provision of drug treatment and various harm reduction services such as methadone maintenance therapy (MMT).^{15,16} International reviews also indicate that HIV epidemics driven by injection drug use can be prevented or reversed by instituting prevention measures while seroprevalence is still relatively low, including such measures as syringe exchange programs and outreach services.¹⁷ Unfortunately, HIV prevention efforts remain inadequate in many countries with high rates of HIV incidence among drug users. For example, the Global HIV Prevention Working Group reported in 2003 that only 11% of injection drug users (IDUs) in the countries of the former Soviet Union and Eastern Europe have access to syringe exchange programs.¹⁸

The Damage of Drug Prohibition

The dominant approach, in both national and international responses to drug use, remains the attempt to reduce or prevent the supply and use of controlled substances by means of legal prohibitions on their cultivation, production, transport, distribution, and possession. Yet the available evidence suggests that drug law enforcement has not produced the purported benefits. Street-level drug policing has been shown to have little, if any, sustained effect on the price of illicit drugs, their availability, or the frequency of use.¹⁹

Nor have law enforcement efforts produced greater use of addiction treatment by drug users.²⁰ Public order gains are generally time-limited and often simply result in displacement of drug markets and drug users into other areas, frequently away from HIV prevention services.²¹ Such ineffective use of policing budgets also carries the opportunity cost of lost investments in other, more beneficial police work (for example, community policing).²² Consider, for example, that the US federal government spends billions of dollars each year to fund the “war on drugs” yet spends nothing on syringe exchange programs, despite hundreds of thousands of documented cases of HIV infection among people who inject drugs.²³

In some cases, prohibition actually fuels risky injection and drug storage practices, increasing the risk of overdose, viral and bacterial disease transmission, and other harms.²⁴ Policies of prohibition have prompted some drug users to switch to drug injection from other practices: drugs consumed by smoking (for example, opium and cannabis) can be harder to conceal than drugs regularly consumed by injection (for example, heroin), and injection may be a more efficient way to consume when the drug supply or time for consumption is limited. Evidence also indicates that law enforcement initiatives can displace drug users into less safe environments (for example, “shooting galleries”) and disrupt relationships within illicit drug markets, leading to increased violence among users and dealers.²⁵ Similarly, policing practices can undermine users’ access to health services, including harm reduction programs. Deterring drug users from visiting syringe exchanges encourages them to share syringes and dispose of syringes and related litter improperly rather than risk being found in possession of such items by police.²⁶ Harassment and arrest of syringe exchange workers, including for possession of material explaining safer injection practices, obviously undermines efforts to protect drug users against HIV and other risks of unsafe use.²⁷ Other reports indicate that fear of prosecution deters many drug users from seeking medical assistance during or following an overdose.²⁸

Harm Reduction Is Health Promotion

Harm reduction does not preclude abstinence as a worthy goal, but rather it accepts that illicit drug use has been, and will continue to be, a feature of cultures throughout the world and that efforts should be made to reduce harms (including HIV infection) among individuals who continue illicit drug use. In practice, interventions aimed at promoting the health of drug users by reducing harms from unsafe drug use and/or facilitating access to care and support include:

- outreach programs;
- peer-driven interventions;
- empowerment through drug user organizations;
- syringe exchange programs;
- opioid substitution therapy (for example, methadone maintenance) and controlled heroin prescription; and
- safer injection facilities and other supervised drug consumption sites.

A large body of evidence indicates that harm reduction measures can have a positive impact in preventing HIV infection among people who use illicit drugs and their sexual and drug-sharing partners; can improve their access to health and other services; and are more respectful of their dignity and rights than other measures.²⁹ Globally, we observe that countries that have adopted comprehensive harm reduction measures have succeeded in preventing or stabilizing HIV epidemics among IDUs; while countries that have been slow to implement such measures and have focused instead on enforcing prohibition have suffered greater spread of HIV among IDUs and subsequent spread to non-drug using populations.³⁰

Outreach programs have been demonstrated to reach marginalized populations, including out-of-treatment IDUs who may be at highest risk for HIV infection, creating an important link to testing, prevention, and treatment services. Peer-driven interventions have been an important means of providing social networks of drug users, through

“indigenous leaders,” with HIV- and overdose-prevention measures.³¹ Drug user-groups connect active users with health services but also play a more critical role in the self-empowerment of users by educating the public about issues facing drug users and effecting policy change through activism.^{32,33}

Syringe exchange programs, which have been found to reduce risk behavior and the incidence of HIV and hepatitis C, have not led to increases in drug use and have been associated with substantial savings in health care expenditures.^{34,35} These programs are widely regarded as the single most important factor in preventing HIV epidemics among IDUs.³⁶ An international investigation found that in cities with syringe exchange or distribution programs HIV seroprevalence decreased by 5.8% per year, while HIV prevalence increased by 5.9% per year in cities without such programs.³⁷ A more recent analysis has suggested an even greater impact on HIV prevalence of the presence or absence of syringe exchange programs.³⁸ Opioid substitution therapy (for example, methadone) has been shown to lead to reduction in, and even elimination of, illicit opiate use, as well as reductions in criminal activity, unemployment, and mortality rates.³⁹ It has also been associated with reduced risk behaviors (for example, needle sharing) and reduced rates of transmission of HIV and viral hepatitis.⁴⁰

Safer injection facilities where IDUs can inject pre-obtained illicit drugs under medical supervision have been implemented in the Netherlands, Germany, Switzerland, Spain, Australia, and Canada.⁴¹ Among other health benefits, they have been associated with reduced HIV-risk behavior and overdose deaths, although further evaluation is warranted.⁴²

Despite evidence supporting the above measures, they often remain unpopular among many politicians; and instead of implementing such programs with proven or reasonably predictable health benefits, many governments have opted to rely on expensive, ineffective, and harmful enforcement policies and practices. In the next section, we consider whether such approaches are required by international drug control treaties and the extent to which governments may pursue more health-friendly alternatives.

Drug Control and Harm Reduction in International Law

The current global system for illicit drug control rests upon three international conventions: the 1961 Single Convention on Narcotic Drugs, the 1971 Convention on Psychotropic Substances, and the 1988 Convention against Illegal Traffic in Narcotic Drugs and Psychotropic Substances (“Vienna Convention”).⁴³⁻⁴⁵ The treaties require signatory states to take various measures to criminalize drug-related activities such as cultivation, production, manufacture, export, import, distribution, trading, and possession of controlled substances except for “medical and scientific purposes.”⁴⁶ The 1998 Convention (Article 3:2) specifically requires the criminalization of possession for personal consumption, casting drug users as criminals.⁴⁷ Three international bodies administer the treaties:

- The UN Commission on Narcotic Drugs (CND) consists of 53 UN member states and is the central policy-making body within the UN system in relation to drug control, with the authority to bring forward amendments to existing treaties or propose new treaties. At the insistence of the United States, the CND currently operates by consensus, meaning that any single country can block a resolution or other initiative.⁴⁸
- The UN Office on Drugs and Crime (UNODC) “assist[s] UN member states in their struggle against illicit drugs, crime and terrorism.” UNODC is a co-sponsor of the Joint UN Programme on HIV/AIDS (UNAIDS) and had begun to show some support for harm reduction measures, at least insofar as it relates to preventing HIV among drug users.⁴⁹ However, recent statements by the senior management have manifested overt hostility toward proven harm reduction measures, even as some parts of the agency support more harm reduction-friendly interpretations. Resolving the consequent internal tension, and contradictions with other “core values” of the UN, is necessary if the UNODC is to be a credible interlocutor in the response to the global AIDS pandemic.⁵⁰

- The International Narcotics Control Board (INCB) is “the independent and quasi-judicial control organ for the implementation of the United Nations drug conventions,” with the “responsibility to promote government compliance with the provisions of the drug control treaties.”⁵¹ Established by the 1961 Single Convention, the INCB consists of 13 individual experts and has manifested a general hostility toward harm reduction. Although the UN conventions enjoin states to ensure drug treatment programs in addition to law enforcement systems, a review of the Board’s annual reports demonstrates that its monitoring activities have focused virtually exclusively on the latter. The INCB has lamented that harm reduction has “diverted the attention (and in some cases, funds) of Governments from important demand reduction activities such as primary prevention or abstinence-oriented treatment.”⁵² Although INCB interpretations of the conventions are not legally binding, they help shape the political climate in which decision-makers determine national drug policies.

The INCB and prohibitionist states have emphasized the provisions in the conventions requiring criminalization and penalties for drug-related activities. However, the treaties also contain important qualifications that can make some space for harm reduction initiatives, even if this “room for manoeuvre” is limited.⁵³ Indeed, the legal advisory branch of UNODC has advised the INCB that most harm reduction measures are compatible with the UN drug control conventions, which can be interpreted to permit opioid substitution therapy, syringe distribution, and safer injection facilities.⁵⁴ As for treaty articles that may be at odds with harm reduction initiatives, the UNODC memorandum stated: “It could even be argued that the drug control treaties, as they stand, have been rendered out of synch with reality.”⁵⁵

So what flexibility currently exists within the drug control regime? The 1961 and 1971 treaties allow for the production, distribution, or possession of controlled substances for “medical and scientific purposes.”⁵⁶ It is up to States

parties to determine how they will interpret such provisions in their domestic legislation. The treaties also allow states to provide measures of treatment, rehabilitation, and social reintegration as alternatives, or in addition, to criminal penalties, meaning that states enjoy discretion in deciding whether or not to impose criminal penalties for the personal (non-medical) possession and consumption of drugs controlled by the treaties.^{57,58} In addition, the 1961 and 1971 conventions actually mandate states to “take all practicable measures” for the “treatment, ... rehabilitation and social reintegration” of drug users.⁵⁹

It is true that the 1988 Convention expressly requires each state to criminalize possession of a controlled substance even for personal consumption. Some have suggested that the provision means that personal consumption is contrary to the 1961 and 1971 Conventions, thereby retrospectively interpreting those earlier treaties.⁶⁰ However, this interpretation is incorrect and should be rejected as it leads to the improper (and often draconian) application of criminal sanctions under domestic legislation that is not strictly required by the treaty. The 1988 Convention merely says that countries must criminalize possession for personal consumption if such consumption is contrary to the provisions of the two earlier treaties; the flexibility found in the earlier conventions is preserved, meaning that possession for personal consumption authorized by domestic law, in accord with the 1961 and 1971 Conventions, is permissible. Importantly, the 1988 Convention also acknowledges that the obligation to criminalize personal consumption is “subject to the constitutional principles and the basic concepts of its legal system.”⁶¹ Given this qualification, the provision is open to creative interpretation, affording some possible leeway for States parties willing to temper prohibition with some ethical concern for the welfare and human rights of drug users in their legal and policy approaches to drug use.

As this brief overview indicates, current international law on drug control is not entirely hostile toward harm reduction. It is, however, hardly satisfactory that any such measures rely upon exceptions, caveats, or particular interpretations of treaties whose overriding purpose is prohibition. In many instances, it is a matter of securing the polit-

ical will to adopt such interpretations and act upon them in the face of great pressure to maintain a strict prohibitionist facade. We return to this in the last section of this article.

Harm Reduction and Human Rights: Conceptual and Normative Links

While the exact parameters of harm reduction may still be the subject of some debate, there is general agreement as to its core content. For present purposes, consider the following working definition, with its noteworthy explicit reference to human rights:

Harm reduction is a pragmatic and humanistic approach to diminishing the individual and social harms associated with drug use, especially the risk of HIV infection. It seeks to lessen the problems associated with drug use through methodologies that safeguard the dignity, humanity and human rights of people who use drugs.⁶²

As suggested by this definition, there is an obvious affinity between harm reduction and human rights. Yet there has been relatively little explicit discussion of the conceptual and normative links between harm reduction and the international law of human rights in academic journals devoted to either of the two fields.⁶³ This has begun to change, particularly as the harm reduction movement — or at least that part of it that articulates the need to change punitive drug laws — has intensified its efforts to reform global drug control policy and grapples with questions of international law.

How are human rights relevant to harm reduction? We suggest that there are a number of inter-connected ways in which harm reduction and human rights are, or can be, linked.

First, the harm reduction movement inherently entails a commitment to the human rights of drug users. Most obviously, as a movement aimed at reducing harms that are sometimes associated with the use of drugs, harm reduction's *raison d'être* is the fulfillment of the human right to enjoy the highest attainable standard of physical and mental health. In addition, harm reductionists are necessarily concerned not only with the direct adverse health consequences

of drug use and laws related to drugs but also with the range of other harms experienced by drug users — including the denial or violation of other human rights. To put it at its most basic, “drug users are people too.”⁶⁴ Although trite, the proposition is regularly disregarded in the ongoing dehumanization of drug users and the tragic daily violation of users’ human rights by both states and non-state actors — from torture to the blatant denial of health care, from harsh sentences of imprisonment to extrajudicial execution. Sadly, therefore, it is a point that must still be made.

Second, from a purely pragmatic perspective, securing human rights is necessary for the success of harm reduction. In an earlier article, Alex Wodak explored how prohibitionist drug policy leads to infringements of various human rights, thereby contributing to the harms suffered by drug users:

Reliance on criminal sanctions as the major response to illicit drug use inevitably results in the denial of human rights of the IDU population as drug use remains defined as a law enforcement rather than a health problem. Poor health outcomes in this population then follow, because health promotion and health care services are more difficult to provide to a now stigmatized and underground population. Protection of human rights is an essential precondition to improving the health of individual drug users and improving the public health of the communities where they live.⁶⁵

Judit Fridli, chair of the Hungarian Civil Liberties Union, points out, similarly, that human rights are necessary preconditions to health improvements for drug users and their communities, suggesting that the political viability of harm reduction practice itself is human rights-dependent:

... Perhaps most importantly, [harm reduction] is about human rights. ... Protection of human rights makes harm reduction — and thus life itself — possible. ... [Some harm reduction methods] will not be started or survive unless they are protected by a public culture of rights and liberties.⁶⁶

Third, as suggested above, human rights norms point toward harm reduction, rather than prohibition, in policy

responses to drug use. At the very least, states are required to remove obstacles to the implementation of such measures by others.⁶⁷ We expand on the human rights-based case for harm reduction — and hence for reform of the international drug control regime — in the next section.

In light of these connections, we suggest that harm reduction advocates can and should deploy human rights norms in making the case for international drug policy reform. But in order to make a human rights case for harm reduction, we first need to clarify what we mean by human rights and what role its principles, norms, and instruments can and should play in a harm reduction analysis.

Andrew Hathaway argues the harm reduction movement has adopted too strictly empirical a focus and has claimed to occupy the “middle-ground” on drug issues, articulating its principles as emerging from a “scientific public health model” but “unduly overlooking the deeper morality of the movement with its basis in concern for human rights.”⁶⁸ In his call for a “morally invested drug reform strategy” (clearly characterizing drug reform as an essential aspect of harm reduction), he criticizes this strategic shortcoming:

As a multidisciplinary movement firmly grounded in the public health perspective ... harm reduction is well-suited for revealing the logical flaws in prohibition by way of empirical analysis. The moral warrants behind the movement to which harm reduction might profitably lay claim, however, are the very principles that have yet to be firmly established and articulated. The greatest challenge for harm reduction, once again, lies in the promotion of its underlying ideals. ... Preferring to keep such ideological, liberty-based values [as respect for free will and human adaptive potential] out of the analysis, harm reduction opts for a morally neutral form of inquiry wherein autonomy and rights have no apparent value in themselves.⁶⁹

Sam Friedman and others have pointed out that the harm reduction movement was formed during a period marked by a “political economy of scapegoating” that targeted drug users, among others, as responsible for social ills; they suggest that “this climate shaped and limited the per-

spectives, strategies, and tactics of harm reductionists almost everywhere."⁷⁰ In a climate hostile to the notion that drug users are entitled to human rights, a pragmatic response to the immediate harms caused by prohibitionist excesses is to cast the problem in the language and data of public health. However, Hathaway is critical of "the rhetorical limitations of an empirical perspective lacking the moral capacity to challenge prohibition on principle, in terms of human rights of users."⁷¹ Without a more fundamental challenge to the barriers blocking humane, rational drug policy, such as the dehumanization of drug users, short-term advances that are urgently needed to prevent and alleviate current suffering will not be sustainable over the long term. "Despite making inroads on pragmatic grounds alone, forsaking deeper principles is short-sighted."⁷²

Hathaway's critique is grounded chiefly in a traditional civil libertarian emphasis on the civil and political rights that governments should refrain from infringing upon, such as liberty, equality, privacy, and freedom from cruel and unusual treatment or punishment — all rights recognized in the International Covenant on Civil and Political Rights.⁷³ While valid as far as it goes, this is but one dimension of a human rights-based understanding of harm reduction.

Equally important is a recognition of the economic and social rights recognized in international law. For example, Nadine Ezard has offered a detailed typology, mapping measures to reduce harm, the risk of harm, and the underlying vulnerabilities against the human rights in which such measures can be grounded.⁷⁴ She argues that our understanding of harm reduction must include not just the reduction of harm and of "risk," but also the reduction of "vulnerability" and the "complex of underlying factors" at the individual, community, and societal level that "constrain choices and limit agency" and thereby "predispose" one to the risk of drug-related harm.⁷⁵ The World Health Organization (WHO) makes the same basic point as Ezard but without explicit reference to human rights: "Successful harm reduction is based on a policy, legislative and social environment that minimizes the vulnerability of injecting drug

users.”⁷⁶ In public health parlance, these are among the “determinants of health.” In legal terms, they are also questions of human rights as recognized in the Universal Declaration of Human Rights and the International Covenant on Economic, Social and Cultural Rights (ICESCR) — such as the rights to security of person, the right to just remuneration and to social security, the right to an adequate standard of living, and the right to enjoy the highest attainable standard of health. Ezard’s call for linking harm reduction with human rights focuses more on the need for positive action by states to address economic and social rights as part of the response to drug use in order to reduce vulnerability to, and risk of, harm.

The Human Rights Case for Harm Reduction ... and for Global Drug Policy Reform

What is the human rights case for harm reduction? And what are the implications of such a rights-based approach for drug policy, whether international or national? The discharge of states’ human rights obligations under international law carries at least two obligations. First, states have a legal duty to implement harm reduction measures that are known to protect and promote health, or that can reasonably be expected to have such benefits.

Second, states must reform the current aspects of prohibitionist drug policy, globally and domestically, which either impede harm reduction measures or cause or contribute to the harms suffered by drug users. The application of international human rights law not only points to the duty of states to address the social exclusion and economic inequities that contribute to harmful drug use, but it also calls into question the prohibitionist legal regimes that cause or exacerbate the harms associated with drug use. Most importantly, if laws and policies aimed at controlling illicit drugs have adverse effects on the health of people who use those drugs, their right to health is jeopardized, and those laws and policies must be compared against the state’s international legal obligations relating to health — including the law of human rights. Because the harms associ-

ated with drug use are inseparable from the environment in which drug use occurs,

... policies that are intended to reduce drug related harms are most effective in supportive environments. This has resulted in increased attention being paid to public health and international human rights law in the attempt to create such an environment. In this context, it is widely agreed that human rights law should apply to drug policies as to all other public policies.⁷⁷

Consider, then, the application of one specific human right. States that are parties to the ICESCR “recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.”⁷⁸ Furthermore, states legally commit to taking steps to realize this right over time, including “those 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.”⁷⁹ The UN committee tasked with monitoring state compliance with the ICESCR has clarified that states’ obligations are threefold — namely, to respect, protect, and fulfill this right.⁸⁰

This means that, absent sufficient justification, states may not adopt policies limiting individuals’ ability to safeguard their health, such as having access to needle exchanges or being able to have access to clean needles in prison. Similarly, states must take positive steps to protect drug users against discrimination by health care providers and to address users’ health needs through facilities and programs.

States are also in breach of their obligation to respect the right to health through any actions, policies, or laws that “are likely to result in ... unnecessary morbidity and preventable mortality.”⁸¹ As described above, there is mounting evidence that enforcing drug prohibitions contributes to the spread of HIV/AIDS, let alone multiple other harms, including violations of various human rights. At what point will a body with sufficient standing draw the conclusion that such enforcement results in unnecessary disease and avoidable death, thereby amounting to an ongoing and massive violation of the human right to health by any state that is party to the ICESCR?

This is but one cursory example of how states' human rights obligations should inform their actions in relation to drug control. It should be remembered that all member states of the UN have pledged to take action to achieve "solutions of international health problems" and "universal respect for, and observance of, human rights."⁸² This is a binding obligation under the UN Charter. Health and human rights are among the apex objectives of the UN. The control of certain narcotic and psychotropic substances, except to the extent that it advances those objectives, is not. Thus, if the international law of human rights mandates a different approach than the prohibitions set out in the UN drug control treaties, how can the latter legal regime be reformed so as to be consonant with states' obligations under the former? We turn to some proposed strategies in the final section.

Human Rights As Normative Counterweight

In considering those strategies, we see the chief function of human rights law as presenting a "normative counterweight" to those harmful aspects of the international legal regime of drug control. We draw here a parallel with recent instances of HIV/AIDS activism in which the law and language of human rights have played just such a role in resolving the conflict between the human rights and public health imperative of access to affordable medicines and the limitations imposed *de jure* or *de facto* by the World Trade Organization's (WTO) Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS), which prescribes certain standards for all WTO members in relation to pharmaceutical patents. As with the case of drug policy reform, conflict over the interpretation and implementation of international intellectual property treaties plays out in both domestic and international arenas and demonstrates how an international legal regime can impede or delay state action that would advance human rights, even within a state's own bailiwick and in the presence of supposed flexibilities and safeguards in that international regime.

Recall, for example, the case of *The Pharmaceutical Manufacturers' Association of South Africa and Others v. The President of the Republic of South Africa and Others*, in which 39 multinational pharmaceutical companies initi-

ated legal action to block the South African government from implementing legislative measures aimed at lowering the cost of medicines.⁸³ Notwithstanding that the South African statute was in conformity with its obligations as a WTO member, the TRIPS Agreement was invoked by countries (chiefly the US) in pressuring South Africa not to implement the legislation, as well as in the pharmaceutical companies' court papers. While the companies ultimately abandoned their application in response to public outrage — and, presumably, in recognition of its weakness on the legal merits — hundreds of thousands of South Africans had fallen ill or died in the interim because they lacked access to needed medicines.

On the international stage, consider the challenge at the WTO from developing countries and health activists that ultimately led to the adoption in November 2001 of the Doha Declaration on the TRIPS Agreement and Public Health (acknowledging the right of WTO members to give health primacy over exclusive patent rights) and the subsequent Decision of the WTO General Council on August 30, 2003 (permitting compulsory licensing of pharmaceutical products for export in significant quantities to countries in need of lower-cost generic medicines).⁸⁴ Even though a policy measure, such as compulsory licensing, is plainly available as a matter of WTO law, both resource-poor and some resource-rich countries have been reluctant to use it to increase access to lower-priced medicines, partly for fear of negative repercussions from powerful countries such as the US.⁸⁵ This reluctance, and the consequent need for an instrument such as the Doha Declaration, illustrate the chilling effect on human rights of an international legal regime whose primary paradigm is the enforcement of intellectual property claims and which powerful states have interpreted in a particularly restrictive manner. The parallel to the UN drug control treaties (or at least their interpretation and the politics of their implementation) should be evident.

The example of treatment activism also bears witness to the importance of deploying human rights norms, both as a matter of principle and as a matter of strategy. This tactic was particularly evident in the domestic context of South

Africa. The Treatment Action Campaign (TAC), the grassroots activist organization leading the struggle for access to care for South Africans living with HIV/AIDS, effectively deployed the language and law of human rights in resisting the pharmaceutical companies' legal action, while simultaneously pressuring the government to develop and implement a national HIV/AIDS treatment plan. Supported by a global advocacy effort, TAC undertook a strategy of popular protest that invoked human rights in tandem with formal intervention, as *amicus curiae*, to advance legal arguments based on both South African and international human rights law. As Mark Heywood has explained, in so doing TAC consciously sought to "turn a dry legal contest into a matter about human lives," not only to place the impugned legislation in its proper context but also to influence public opinion.⁸⁶ Through its invocation of human rights, TAC altered both the public discourse and the issues at play in the court action, effectively counter-balancing a lopsided focus solely on intellectual property law.

Similarly, on the international stage, it was necessary to generate a political environment supportive of countries wishing to use the "flexibilities" in the WTO's TRIPS Agreement to implement measures such as compulsory licensing to facilitate access to more affordable medicines. Consequently, developing countries and health advocates created countervailing normative forces in other arenas of international law and diplomacy. In doing so, they succeeded in re-shaping international policy. For example, months before the 2001 WTO Ministerial Conference that adopted the Doha Declaration, Brazil succeeded in obtaining a resolution at the UN Commission on Human Rights, declaring that "access to medication is one fundamental element for achieving progressively the full realization of the right of everyone to the enjoyment of the highest attainable standard of physical and mental health."⁸⁷ The resolution specifically grappled with the conflict between the right to health and the patent rules of the WTO regime. Updated to reflect subsequent developments (such as the WTO Doha Declaration), the resolution has since been adopted at a number of Commission sessions (by consensus,

including the US), thereby solidifying recognition in international law of the right to health and the specific aspect of access to medication.

The example of treatment activists challenging the international intellectual property regime is instructive for harm reduction advocates. Injecting human rights into the global debate over drug policy can bring to bear principles and norms that make visible the human suffering caused by a zealous insistence upon harmful prohibitionist approaches. As in the case of treatment activism, “rights talk” in the struggle for harm reduction asserts that concern for the welfare of those who are excluded and marginalized is not simply a matter of charitable humanitarianism. Rather, it establishes that drug users are rights-bearers, whose rights are disrespected through the deliberate application of policies known to produce avoidable suffering and death, and who have a moral and legal claim to the means of promoting and protecting their health. “Rights talk” also insists that states have an obligation, and not merely an option, to respect, protect and fulfill that right (and others) in developing and implementing legislation, policy, and other measures. The language and law of international human rights provide not only an underpinning for harm reduction’s “moral warrants” but also a set of norms that states and others can invoke in making the case for more health-friendly global policies on drug control. This can complement the growing public health evidence demonstrating the damage of prohibition and the benefits of harm reduction. The pressure for reform of the UN drug control regime will grow over the coming years, and human rights analysis should, in our view, be part of revisiting the current treaties.

Regime Change: Strategies for Reforming Global Drug Policy⁸⁸

We noted above that, at least in theory, States parties to the UN drug control conventions retain some flexibility to implement harm reduction measures and that challenges to strictly prohibitionist interpretations are growing. For example, under pressure, the INCB has accepted that both substitution therapy and needle exchange programs are “per-

missible" under international drug control treaties (although methadone remains classified on the schedule of the most tightly controlled drugs under the drug control treaties).⁸⁹ The Commission on Narcotic Drugs has "taken note" of this INCB position.⁹⁰ However, other important harm reduction measures remain contested. For example, in 2000, the INCB issued a statement decrying what it called "drug injection rooms" — which it equated with "shooting galleries" and "opium dens" — as "a step in the direction of drug legalization."⁹¹ It ignores the fact that safer injection facilities serve "medical and scientific purposes," and has stated that any government that allows such sites "facilitates drug trafficking" and contravenes the UN conventions.⁹² This criticism provides convenient cover for national governments opposed to such measures. Similarly, the widely accepted (albeit incorrect) view that the 1988 Convention requires States parties to criminalize even possession of illicit drugs for (non-medical) personal consumption — thereby rendering all drug users criminal offenders — further narrows the room for maneuver for states willing to treat drug use as primarily a health issue rather than a criminal one.

Furthermore, even if states have some interpretive leeway in complying with their obligations under the drug control treaties and can muster the political will domestically to forge ahead with harm reduction initiatives, the larger political environment limits the amount of "policy space" that they can open up. The structural inertia of the CND operating on consensus among member states, the internal contradictions within the UNODC, and the ideological opposition of the INCB hardly make for a supportive global framework. Finally, many powerful countries are committed to the prohibitionist agenda.⁹³ Consequently, as is often the case with international instruments, it is as much (or even more) a question of politics as it is law. As Robin Room puts it: "The impact of the system comes instead from the implementation of the treaties, and with the international politics that surrounds that."⁹⁴ He describes "an international environment where states have been reluctant to break openly with a governing orthodoxy de-

scribing drug control in terms of a war on drugs."⁹⁵

Yet "cracks in the consensus" are emerging.⁹⁶ A number of countries are shifting away from, or at least tempering, criminalization as their dominant approach to illicit drugs. The UN General Assembly will next debate global drug policy in 2008, a decade after its Special Session on Drugs and the adoption of various declarations largely reaffirming the prohibitionist goal of eradicating "drug abuse." Therefore, the next few years call for strategies to reform the current regime. What might the options be?

Given the need for consensus, the chances of amending the existing conventions are slim at best. Advocates' limited time and resources are likely spent better elsewhere. Similarly, adopting a new convention on harm reduction would be a very long-term project facing the same challenges. Of course, such efforts would have the benefit of squarely engaging states in a discussion that can gradually shift political consciousness and call into question the sanctified status of prohibition. But millions of drug users across the globe are facing a current and ongoing health crisis; while longer-term strategies are important, they need to be complemented by more pragmatic, short-term steps.

In theory, some more progressive states might be convinced to *denounce* (that is, withdraw from) one or more of the conventions, but this is unlikely. Aside from domestic political considerations, any single state taking such a step "would have to be prepared to face not only US-UN condemnation but also the threat or application of some form of US sanctions" against what would be condemned as a "pariah narcostate."⁹⁷

However, a more feasible and interim approach would be to promote a strategy of "collective withdrawal." A critical mass of like-minded states could form a coalition that would state, in some formal instrument introduced in relevant UN bodies, their interpretation of which harm reduction measures are permissible under the existing drug control conventions and, if necessary, identify those aspects of the treaties from which they are withdrawing.

Such a step by progressive states would be unlikely to happen without coordinated advocacy by civil society or-

ganizations. Support from UN bodies with relevant mandates would strengthen the position of such states, and therefore, harm reduction advocates need to engage with those bodies as well, focusing on those most likely to be sympathetic and those whose support would be most helpful.⁹⁸ For example, UNAIDS and WHO could bring to their governing boards, for endorsement, a policy that would encourage states to ensure the implementation of harm reduction measures. The committees that monitor the implementation of UN human rights treaties, the Office of the High Commissioner for Human Rights, and the special rapporteurs should incorporate concerns about the human rights impacts of the war on drugs and the human rights benefits of harm reduction measures into their work. Resolutions could be brought before the UN Commission on Human Rights and the World Health Assembly affirming the human rights of drug users and recognizing the right of sovereign states to implement harm reduction measures. Several of these UN agencies could jointly submit a report to the Commission on Narcotic Drugs, including strong support for harm reduction measures and for protecting and promoting the human rights of drug users, that could inform resolutions emanating from the Commission. Civil society advocates can intervene directly or indirectly in these various processes with evidence, arguments, and documentation that make the case for a more rational, human rights-friendly approach to drug policy. In addition, UNODC should be encouraged to manifest public support for harm reduction; and the UN Secretary General, who has stated his personal commitment to responding to the global AIDS crisis, should show leadership by speaking out publicly against violations of drug users' human rights.

Conclusion

The majority of the world's countries have ratified one or more of the UN drug control conventions that mandate drug prohibition and its enforcement as the dominant response to the use of certain drugs. Consequently, the international legal regime, backed by powerful states and some UN bodies, affects the possibilities for national-level reform

across the globe. It is, therefore, of common concern to all those who can witness the human and economic devastation wreaked by the war on drugs. Harm reduction measures are an important component of the larger struggle to realize fully the human right to health of all people who use illicit drugs. A harm reduction approach to drugs must be pursued by pushing for more health-friendly interpretation and implementation of the existing drug control treaties and by pursuing complementary strategies for reforming them. The harm reduction and human rights movements enjoy a close kinship; further exploration of the conceptual links and the role that human rights advocates can play in the harm reduction movement would benefit each. Collaboration will increase the likelihood of effecting regime change at the global and domestic levels, and in turn, has the potential to greatly reduce the burden of HIV infection among injection drug users.

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60. Bewley-Taylor and Fazey (see note 4).
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62. *What Is Harm Reduction?* (New York: International Harm Reduction Development Program, 2004).
63. We note that concern for human rights makes repeated appearances in much of the "grey" literature, and certainly in discussions within the harm reduction movement, including some analysis that explicitly references sources of international human rights law.
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66. J. Fridli, "Harm Reduction Is Human Rights," *Harm Reduction News* 4/1 (2003): p. 3.
67. For a more detailed discussion of this point, specifically as it relates

to removing barriers to experimenting with one particular harm reduction measure, see I. Malkin, R. Elliott, and R. McRae, "Supervised Injection Facilities and International Law," *Journal of Drug Issues* 33/3 (2003): pp. 538-78.

68. A. D. Hathaway, "Shortcomings of Harm Reduction: Toward a Morally Invested Drug Reform Strategy," *International Journal of Drug Policy* 12 (2001): pp. 125-37.

69. *Ibid.*: pp. 135-36.

70. S. R. Friedman et al., "Harm Reduction — A Historical View from the Left," *International Journal of Drug Policy* 12 (2001): pp. 3-14.

71. Hathaway (see note 67): p. 133.

72. *Ibid.*: p. 126.

73. In this same libertarian vein, one author has proposed a new article in the UDHR affirming the right to use psychotropic substances of one's own choice. Van Ree invokes standard liberal utilitarian principles, arguing that only limited restrictions on the individual freedom to use drugs may be justified, in the interests of preventing harms to others. Taken to its logical conclusion, he suggests that recognition of such a right would inevitably require an end to the war on drugs: E. van Ree, "Drugs As a Human Right," *International Journal of Drug Policy* 10 (1999): pp. 89-98. Hathaway does not take his analysis this far, although such a position certainly seems consistent with, and perhaps even implicit, in his call for respecting personal autonomy.

74. N. Ezard, "Public Health, Human Rights and the Harm Reduction Paradigm: From Risk Reduction to Vulnerability Reduction," *International Journal of Drug Policy* 12 (2001): pp. 207-219.

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