Human Rights, Health and Harm Reduction

States' amnesia and parallel universes

An address by Professor Paul Hunt
UN Special Rapporteur on the right to the highest attainable standard of health

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About the International Harm Reduction Association and HR2

The International Harm Reduction Association (IHRA) is one of the leading international non-governmental organisations promoting policies and practices that reduce the harms from all psychoactive substances, harms which include not only the increased vulnerability to HIV and hepatitis C infection among people who use drugs, but also the negative social, health, economic and criminal impacts of illicit drugs, alcohol and tobacco on individuals, communities and society. A key principle of IHRA's approach is to support the engagement of people and communities affected by drugs and alcohol around the world in policy-making processes, including the voices and perspectives of people who use illicit drugs.

In 2007, IHRA established HR2, the Harm Reduction & Human Rights Monitoring and Policy Analysis Programme. HR2 leads the organisation's programme of research and advocacy on the development of harm reduction programmes and human rights protections for people who use drugs in all regions of the world.

IHRA is an NGO in Special Consultative Status with the Economic and Social Council of the United Nations.

About the Author

In 1998, Paul Hunt – a national of New Zealand – was elected by the United Nations to serve as an independent expert on the UN Committee on Economic, Social and Cultural Rights (1999—2002). Between 2001—2002, at the request of the then UN High Commissioner for Human Rights, Mary Robinson, he co-authored draft Guidelines on Human Rights Approaches to Poverty Reduction.

Between 2002-2008, Paul served as UN Special Rapporteur on the right to the highest attainable standard of health, the first appointment to this new human rights mechanism. As Special Rapporteur, he endeavoured to help States and other actors better promote and protect the right to health. In his work, he focused in particular on poverty, discrimination and the right to health. An independent expert, he undertook country missions and reported to the UN General Assembly and UN Commission on Human Rights (now the UN Human Rights Council).

Paul has lived and undertaken human rights work in Europe, Africa, the Middle East and South Pacific. He has written extensively on economic, social and cultural rights. He is a member of the Human Rights Centre, at the University of Essex (England) and Adjunct Professor at the University of Waikato (New Zealand).

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The following is the text of Professor Hunt's keynote address at the Opening Plenary of Harm Reduction 2008: IHRA's 19th International Conference, Barcelona, 11 May 2008.

People who use drugs are routinely subject to multiple human rights violations:

- An ambulance refuses to respond to a drug overdose because the underlying activity is 'illegal'.
- People who use drugs die in a locked hospital ward engulfed by fire.
- Police beat people suspected of using drugs.
- People who use drugs undergo treatment, including detoxification, without their consent.
- Investigators force drug suspects into unmedicated withdrawal to extract confessions.
- Doctors disclose patients' history of drug use without consent.
- Police raid the home of a suspected drug user without lawful authorisation.
- People who use drugs are denied information about HIV prevention, harm reduction, and safer drug use.
- Governments ban publications about drug use or harm reduction.
- Government officials harass individuals who speak publicly in favour of needle exchange, methadone or other harm reduction measures.
- Public authorities refuse to register a drug user association.
- Police break up a peaceful demonstration against drug laws.
- Police fail to investigate a case of domestic violence against a drug-using woman.
- Police fail to investigate the assault or murder of a person suspected of using drugs, blaming it on 'gang violence'.
- A person is denied health care due to actual or suspected drug use.
- In some countries, people who use drugs are underrepresented in HIV treatment programmes despite accounting for the majority of people living with HIV.
- Government officials ban needle exchange programmes.
- Government officials ban substitution therapy with methadone.
- Women are denied access to harm reduction services on an equal basis with men.
- Young people who use drugs are denied factual information and services about safer injection and harm reduction.
- People who use drugs are excluded from consultations about proposed harm reduction policies and programmes.

Drawn from every region of the world, the human rights indictment is long.[1] And this is not the end of it. From your own experiences, you can all provide many additional examples.

This widespread, systemic abuse of human rights is especially shocking because those who use drugs include people who are the most marginal - the most vulnerable - in society.

Despite this – despite the scale of abuse and the vulnerability – there is no public outrage, no public outcry. On the contrary, the long litany of abuse scarcely attracts disapproval. Sometimes it even receives public support.

Why? Because in many societies people who use drugs are invisible, stigmatised or demonised. And history teaches us that when this happens – when a group of people are invisible, stigmatised or demonised - widespread human rights abuse often follows.

This is precisely what is happening – in many countries – to people who use drugs. And not just in authoritarian regimes. It is happening in democratic countries, too. A famous commentator once warned against the 'tyranny of the majority'. Systemic injustice and neglect is not confined to dictatorships.

The historic role of human rights is to expose and challenge such injustice. Wherever it occurs and whatever form it takes. Whether the injustice is at the hands of a dictator or a democracy. Whether those affected are popular or not. Whether they are visible or hidden.

The United Nations and human rights

The United Nations was established in response to appalling human rights violations on a horrendous scale. For this reason, one of the three principal objectives of the United Nations is the promotion and protection of human rights for all, without discrimination.

For many years, human rights attracted limited attention – and few resources – within the United Nations. In part, they were victims of the Cold War.

Despite the Cold War, significant progress was made. An elaborate international code of human rights was negotiated – word by word – and agreed. This was an extremely arduous process. Reading the histories of these important texts, I am reminded of hand-to-hand combat. Every human right – every principle – every phrase – was hard fought. In this struggle, non-governmental organisations (NGOs)

played a critical role. Without civil society, there would be no international code of human rights as we know it today.

The code includes numerous international treaties, as well as many important declarations. The entire edifice rests upon the Universal Declaration of Human Rights – whose 60th anniversary we celebrate this year. There is a global campaign to mark this anniversary. Its slogan is 'Dignity and justice for all of us'.

All of us: including people who use drugs.

This slogan signals among the most important features of the international code of human rights: equality and non-discrimination. Human rights have a particular preoccupation with marginal groups, vulnerability, disadvantage and discrimination.

Of course, it is easy to dismiss this international code of human rights. After all, every day our newspapers remind us that the code is breached with impunity: Darfur, Burma, Zimbabwe, Israel/Palestine, Guantanamo Bay, and so on.

Nonetheless, I encourage you to include international and national human rights in your strategies. Human rights are blunt instruments. And sometimes they appear to have no impact at all. But it is also undeniably true that sometimes human rights have helped in the struggle against injustice.

As the international code of human rights was being negotiated, national and international mechanisms were put in place to check that the code was being implemented. Crucially, much of the code is legally binding upon States – so processes were established to hold States to account in relation to their legally binding obligations.

Today, there are many national and international procedures that can be used – and are being used – to expose and challenge the abusive conduct of governments. Once again, these procedures depend upon civil society. In recent years, for example, non-governmental organisations have taken literally thousands of human rights law cases – and some of these cases have generated progressive reforms to laws and policies.

Of course, we all know that litigation has very serious limitations. I cannot see those using drugs lining up outside the law courts with their

test cases. But not all human rights accountability procedures involve the courts.

For example, there is a human rights treaty called the International Covenant on Economic, Social and Cultural Rights. Over 150 States have agreed to be bound by this important Covenant that includes a range of human rights, including the right to the highest attainable standard of health. Although the Covenant's rights are subject to progressive realisation and resource availability, these phrases do not provide States with an escape hatch.

Every five years, each of the 150 States has to submit a long report setting out how they are implementing all the rights in the Covenant. The report goes to an international committee of human rights experts. The international experts are independent. The State sends a delegation to present their report to the committee. The independent experts ask the delegation questions about the State's report. The questions often draw from briefings prepared by civil society. These NGO 'shadow reports' are crucial. Sometimes, reading a State's report along side an NGO's 'shadow report', you would think they are describing different countries.

Informed by the 'shadow reports', the independent experts can ask the State officials hard questions. What are you doing about police violence against those who use drugs? Why has your government banned substitution therapy with methadone? Why has it banned needle exchange programmes? Why are you not educating your young people about harm reduction? What harm reduction initiatives do you have in place? How much of the budget is devoted to harm reduction? Why is this sum less this year than it was last year? How is that consistent with your government's duty to progressively realise the right to the highest attainable standard of health? Do you listen to people who use drugs to learn about their views and experiences?

This dialogue takes about one day – and it takes place in public in Geneva. NGOs are usually sitting at the back of the room listening. At the end of the dialogue, the committee prepares some criticisms of the State's laws and policies. And it also prepares some recommendations. These are made public – put on the web – and published in all six UN languages.

For four years, [2] I sat on this committee and I can assure you that when we prepared our criticisms and recommendations we were often

trying to create something that would be useful to civil society organisations – something that NGOs could use in their campaigns – something they could take to their governments and say: 'Look, the UN is criticising you for being in breach of your international human rights obligations, it is time to introduce reforms, adopt the UN's recommendations.'

When I was on that committee, my colleagues and I received a very large number of 'shadow reports' from NGOs on many countries and on many issues – from domestic violence to the right to education and the right to the highest attainable standard of health.

But I have no recollection of ever receiving any NGO information about harm reduction and the human rights of those who use drugs.

I am pleased to report that this is changing. Last year, for example, the Swedish Drug Users Union, and the International Harm Reduction Association, submitted a 'shadow report' to a United Nations human rights treaty-body. [3]

Of course, you must have no illusions about human rights protections and procedures. For example, the process I have just outlined is very weak. Sometimes NGOs invest precious resources into preparing 'shadow reports' with no significant outcome.

Still, human rights do provide a way of holding States to account - of making sure that people who use drugs are not invisible – of exposing stigma, discrimination and other abuse – of asking tough questions and demanding clear answers - and so I respectfully suggest that you consider the strategic use of human rights and their procedures.

Although these human rights bodies and procedures are flawed, they are models of transparency, accessibility and participation when compared with the bodies and procedures associated with the international drug control system, such as the International Narcotics Control Board. But that serious problem deserves a separate presentation. [4]

UN Special Rapporteurs are another type of independent mechanism for the promotion and protection of human rights. The mandates of several Special Rapporteurs, such as those working against torture and extra-judicial executions, bear upon those who use drugs. Rapporteurs are not members of the UN secretariat; they usually report directly to the UN General Assembly and UN Human Rights Council.

My mandate is on the right to the highest attainable standard of physical and mental health. This fundamental human right extends beyond medical care to also encompass the underlying determinants of health, such as access to water, sanitation and health-related information. Because the right is subject to resource availability, more is demanded of a high-income than a low-income State. Also, because the right is subject to progressive realisation, a State must have in place indicators and benchmarks to measure the degree to which it is successfully improving (or otherwise) health processes and outcomes. There must be accountability mechanisms to hold the State (and others) to account in relation to its right-to-health duties. [5]

The right to the highest attainable standard of health requires all States to provide, as a matter of priority, national, comprehensive harm reduction services for people who use drugs. An appropriate policy, plan, budget, monitoring and accountability must support the services. As the services, policy and so on are formulated and implemented, mechanisms must be in place to enable the active and informed participation of those most affected.

One size does not fit all. Harm reduction initiatives must respond to national and local needs. Also, as already observed, the right to health places greater demands on high-income than low-income States. All States, however, are obliged to have an effective, national, comprehensive harm reduction policy and plan, that delivers essential harm reduction services.

In 2006, the Swedish Government invited me to look at the right to health in Sweden. My UN report gives the Government credit for a standard of living, life expectancy and health status that is among the best in the world. But my report also highlights some significant problems. [6]

For example, I was surprised and disappointed to find a seriously inadequate approach to harm reduction. So my UN report reminds the Swedish Government of its right to health responsibility to ensure implementation of a national, comprehensive harm reduction policy, throughout the country, as a matter of priority.

States' amnesia, parallel universes and the challenge of policy coherence

But I want to highlight a much wider problem that goes beyond Sweden or any individual country.

Governments suffer from acute amnesia. I talk to them in the UN Human Rights Council about the right to the highest attainable standard of health. The Council passes resolutions affirming the right to health and requesting me to prepare reports on various right-to-health issues.

Then the representatives of the same Governments that sit on the Human Rights Council walk up the hill in Geneva to the World Health Organisation – or they take the plane to Vienna and the UN Commission on Narcotic Drugs – and somewhere en route they forget about their legally binding right to health duties.

This is especially bizarre because the UN General Assembly has expressly mandated the UN Human Rights Council to take steps to integrate human rights across the world organisation.[7]

This leads to the inexcusable situation that the UN Commission on Narcotic Drugs focuses almost exclusively on three international drug conventions with scant regard for the international code of human rights that emerges from one of the principal objectives of the UN Charter.

It is imperative that the international drug control system – the UN Commission on Narcotic Drugs (CND), the UN Office on Drugs and Crime (UNODC), the International Narcotics Control Board and so on – and the complex international human rights system that has evolved since 1948, cease to behave as though they exist in parallel universes.

The UN human rights system must give closer attention to the international drug conventions, the issue of drug control, and the plight of those who use drugs.

Equally, the international drug control system must be respectful of human rights. This is not an option. It is a legal requirement. [8]

There are some modest but encouraging signs that these parallel universes – these silos – are breaking down. Take, for example, the recent resolution of the UN Commission on Narcotic Drugs requesting UNODC 'to continue to work closely with' the UN human rights system. [9] One hopes this will lead to more cooperation and not merely the maintenance of the

deeply unsatisfactory status quo. Also, UNODC's Executive Director, Antonio Maria Costa, deserves credit for acknowledging in a recent speech to CND that 'implementation of the drug Conventions must proceed with due regard to human rights. Thus far, there has been little attention paid to this aspect of our work. This definitely needs to be amended.' [10]

Operationalisation

The challenge is to operationalise this commitment – to take forward these modest moves towards greater policy coherence. Fortunately, recent developments will help.

Like other parts of the wider human rights movement, health and human rights have matured rapidly in recent years.

Not long ago, the health and human rights movement focussed on 'naming and shaming', taking test cases, letter writing campaigns and slogans. All these traditional human rights tools continue to have a vital role to play. However, there is now a growing recognition that human rights must shape health policies, programmes and projects. They must be integrated into national and international policy making processes. And for this to happen the traditional human rights tools are no longer sufficient. In addition, we need impact assessments, indicators and benchmarks (because of progressive realisation), budgetary analysis (because of resource availability), and so on. Moreover, recent years have seen the health and human rights movement developing these more sophisticated tools and techniques. [11]

Consistent with this more mature approach – and in keeping with the General Assembly's view that human rights must be integrated across the UN – the human rights community is developing a human rights based approach to development; a human rights based approach to poverty reduction; a human rights based approach to trade; and so on.

And I have no doubt that it is now time to develop a human rights based approach to drug policy.

Drug policy is not simply a law and order issue. It is also a human rights issue. And we must reshape the drug policy agenda accordingly. [12]

As the General Assembly has confirmed, it is time for human rights to take their rightful place, integrated across the United Nations, making policies and programmes more effective, inclusive, accessible,

transparent, robust, sustainable and meaningful to those who are disadvantaged.

Conclusion

Sometimes human rights, including the right to the highest attainable standard of health, are characterised as unrealistic and impractical.

This is a gross misrepresentation.

The right to health demands initiatives that deliver good health outcomes by way of transparent, participatory, non-discriminatory processes.

Right to health initiatives are evidence-based – or at least evidence-informed.

In relation to harm reduction, this is extremely important.

There is overwhelming evidence that harm reduction initiatives work. They are good for public health. They reduce avoidable suffering. They save lives. Moreover, these benefits extend beyond HIV prevention to protecting people who inject drugs, and their partners, from the wide range of other negative health consequences associated with injecting drug use. And the initiatives are also cost effective. [13]

If that is not realistic and practical – I do not know what is!

When human rights workers call for harm reduction initiatives, it is not they that are impractical, it is not they that are blindly driven by ideology – it is their opponents.

At the heart of the right to the highest attainable standard of health lies an effective and integrated health system, encompassing health care and the underlying determinants of health, which is responsive to national and local priorities, and accessible to all. The health system must be responsive to the particular needs of disadvantaged individuals and communities, including people who use drugs.

From the right to health perspective, a health system must include a 'basket' of health services – and this 'basket' must include harm reduction services. But, in addition, the right to health requires that a health system has certain other vital features, such as outreach programmes for the disadvantaged, effective referral systems, arrangements to ensure the participation of those affected by health decision-making, respect for cultural difference, monitoring and accountability mechanisms, and so on. [14]

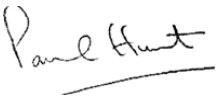
I suggest that when working for the human rights objective of enhanced harm reduction services, the overarching goal should be a strong, accessible, integrated health system that is sensitive to the distinctive needs of all, including people who use drugs.

The overarching goal should be a strong, accessible, integrated health system which has those features demanded by the right to the highest attainable standard of health.

Human rights do not provide magic solutions to complex issues because there are no magic solutions.

But human rights have a constructive contribution to make.

I urge you to integrate them into your inspiring work.



Endnotes

1. See, for example, Catherine Cook and Natalya Kanaef, Global State of Harm Reduction 2008, International Harm Reduction Association, and chapter 3 of Health and Human Rights: a Resource Guide for the Open Society Institute and Soros Foundations Network, Open Society Institute/Equitas, 2007.

2. 1999—2002.

3. The UN Committee on Economic, Social and Cultural Rights. See Swedish Drug Users Union and International Harm Reduction Association, Briefing to the Committee on Economic, Social and Cultural Rights on the fifth report of Sweden on the implementation of the International Covenant on Economic, Social and Cultural Rights, October 2007.

4. 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.

5. See Helen Potts, Accountability and the Right to the Highest Attainable Standard of Health, University of Essex, 2008.

6. The report (A/HRC/4/28/Add.2) dated 28 February 2007 can be found at: http://www2.essex.ac.uk/human_rights_centre/rth/docs/sweden.pdf

7. See A/RES/60/251.

8. In this context see, for example, the UN General Assembly resolution stating 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." UNGA Res 61/183 (13 March 2007) UN Doc A/RES/61/183 para 1.

9. Resolution 51/12.

10. 10 March 2008.

11. For a discussion about the health and human rights movement's progress and obstacles see the report (A/HRC/4/28) dated 17 January 2007 accessible at: http://www2.essex.ac.uk/human_rights_centre/rth/docs/council.pdf

12. See, for example, Damon Barrett, Rick Lines, Rebecca Schleifer, Richard Elliott and Dave Bewley-Taylor, Recalibrating the Regime: The Need for a Human Rights-Based Approach to International Drug Policy, Beckley Foundation Drug Policy Programme and International Harm Reduction Association, 2008.

13. See, for example, Alex Wodak and Annie Cooney, Effectiveness of sterile needle and syringe programming in reducing HIV/AIDS among injecting drug users (2004), WHO; 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.

14. For the key right-to-health features of a health system, see A/HRC/7/11 dated 31 January 2008, accessible at: http://www2.essex.ac.uk/human_rights_centre/rth/docs/A-HRC-7-11.doc

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