International Centre
on Human Rights
and Drug Policy

The Promotion and Protection of Economic, Social, and Cultural Rights & International Drug Control

Compilation of joint submissions by the International Centre on Human Rights and Drug Policy to the United Nations Committee on Economic, Social, and Cultural Rights

2016-2018

CANADA:
Drug policy and economic, social, and cultural rights

Submission to the Committee on Economic, Social, and Cultural Rights

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Canadian HIV/AIDS Legal Network and
International Centre on Human Rights and Drug Policy
1 February 2016

I. General Information: Drug policy and economic, social and cultural rights

Canada is a party to the three main UN drug control conventions, which aim to control illicit drugs by reducing supply and demand, in particular through requiring States Parties to adopt varying degrees of prohibitions and sanctions on a range of designated controlled substances, while also providing some degree of (often contested) flexibility for States Parties in their approach.[1] However, Canada must also fulfill its domestic constitutional obligations under the *Canadian Charter of Rights and Freedoms*, as well as those under international human rights law, including the *International Covenant on Economic, Social and Cultural Rights,* which Canada has ratified. These human rights obligations bind the state in its response to drugs.

Yet, when poorly developed and implemented, drug policies can lead to serious violations of economic, social, and cultural rights, including discriminatory arrest and penalization, denial of social benefits and custodial rights, police harassment and violence, arbitrary detention of minority groups, coercive medical treatment, systemic denial of essential medical interventions, and other violations of the right to health. Many of these policies and practices fuel stigma, exacerbate existing inequality, and undermine the progressive obtainment of entitlements guaranteed under the ICESCR. The health and human rights of indigenous communities across the globe have been acutely affected, including indigenous communities in Canada.

In 2007, the Government of Canada launched a new National Anti-Drug Strategy. This new strategy expanded a punitive drug control framework, eliminating the long-standing element of *harm reduction* as part of the Government's response to drugs. This new model then led to a series of "tough on crime" laws, policies and other measures by the Government of Canada, including mandatory minimum sentences for certain drug-related offenses and active efforts by the federal government to prevent the introduction of evidence-based harm reduction programs across the country.

In light of the Committee's current review of Canada's implementation of the International Covenant on Economic, Social, and Cultural Rights, please find below a brief overview of our main concerns related to Canadian drug law and policy.

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[1] United Nations, *Single Convention on Narcotic Drugs* (1961), as amended by the 1972 Protocol amending the *Single Convention on Narcotic Drugs*; United Nations, *Convention on Psychotropic Substances* (1971); United Nations, *Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances* (1988).

II. Issues related to general provisions of the Covenant

Maximum available resources

The new drug strategy introduced in 2007 directed the majority of new funding towards law enforcement under the *Controlled Drugs and Substances Act*.[2] A review conducted in 2009 showed that law enforcement received the overwhelming majority of funding for the drug strategy (70%) while prevention (4%), treatment (17%) and harm reduction (2%) combined only received (less than) a quarter of the overall funding.[3] Despite obligations under the ICESCR (Articles 2 and 12) to ensure maximum available resources are directed towards the progressive realization of the right to the highest attainable standard of health, budgetary allocation for essential health interventions, including drug dependence treatment and harm reduction for some of Canada's most vulnerable communities, has been displaced by politically-motivated enhancement of the enforcement of punitive laws, including mandating minimum periods of incarceration, including for small-scale drug offences.

Non-discrimination

We are concerned that Canada's current national drug policy does not adequately reflect the principle of non-discrimination – and in fact, in both intent and effect, actively discriminates in various ways contrary to its international human rights obligations under various conventions, including ICESCR. We note three examples in brief below: (1) the ongoing criminalization of possession of substances for personal use; (2) recently-enacted mandatory minimum prison sentences for certain drug offences; and (3) recently-enacted impediments to access to health services.

First, Canada's ongoing **criminalization of possession of controlled substances for personal consumption** further stigmatizes and marginalizes people who use drugs. It amounts to criminalization of people with addiction – which is recognized as a disability under Canadian law.[4] It also runs contrary to recommendations from a variety of international bodies, including the Office of the UN High Commissioner for Human Rights (OHCHR)[5] and various UN specialized agencies such as UNAIDS, WHO and UNODC.[6]

Second, despite opposition from public health officials and leading human rights experts, in 2012 the federal Parliament enacted the *Safe Streets and Communities Act*, which created new **mandatory minimum sentences of incarceration for certain drug offences**.[7] While the federal government of the day claimed the law only

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[2] Canadian Drug Policy Coalition, *Getting to tomorrow: a report on Canadian drug policy*, 2013, online: http://drugpolicy.ca/report/CDPC2013_en.pdf;

[3] K. De Beck et al., "Canada's new federal 'National Anti-Drug Strategy': an informal audit of reported funding allocation," *International Journal of Drug Policy* 2003; 20(2):188-191.

[4] *Canadian Human Rights Act*, RSC 1985, c. H-6. Section 25 of the Act defines "disability" as follows: "disability means any previous or existing mental or physical disability and includes disfigurement and previous or existing dependence on alcohol or a drug."

[5] UN General Assembly, *Study on the impact of the world drug problem on the enjoyment of human rights: Report of the United Nations High Commissioner for Human Rights,* UN Doc. A/HRC/30/65 (4 September 2015), online: http://www.ohchr.org/EN/HRBodies/HRC/RegularSessions/Session30/Documents/A_HRC_30_65_E.docx.

[6] E.g., UNAIDS, *A Public Health And Rights Approach to Drugs* (Geneva, 2015), online: http://aidsdatahub.org/sites/default/files/publication/A_public_health_and_rights_approach_to_drugs_2015_0.pdf;

[7] *Letter to Government Expressing Opposition to Bill S-10,* February 6, 2011, online: http://uhri.cfenet.ubc.ca/content/view/88; Canadian Bar Association, *Submission on Bill C-10, Safe Streets and Communities Act,* at http://www.cba.org/cba/submissions/PDF/11-45-eng.pdf; Canadian HIV/AIDS Legal Network, *Brief to*

targets "serious drug crimes," the new minimum prison sentences mandated by the new law are likely to disproportionately affect individuals from vulnerable and marginalized populations, thus perpetuating systemic discrimination already well-documented in the criminal justice and correctional systems.[8] In fact, the disproportionate, discriminatory impact of mandatory minimum sentences for drug offences affects in particular the following populations:

- **people struggling with problematic substance use**, as reflected in the fact that the federal prison system's own data reports that some 80% of those incarcerated federally have experience of either former or current substance use;
- **Indigenous people**, who both experience substantially higher rates of addiction and are vastly over-represented in Canada's prisons – and both of these facts are ones of which the Supreme Court of Canada and other courts have repeatedly taken judicial notice;
- **black people**, whose rates of incarceration in federal prisons have significantly increased in recent years, according to the federal correctional ombudsman, far out of proportion to their representation in the Canadian population as a whole; and
- **women**, given the even higher proportion of problematic drug use reported among women – and particularly among Indigenous women – in Canadian prisons than among men.

With regard to the disproportionate, discriminatory impact on the grounds of disability (i.e., addiction), race and sex of such harsher, punitive drug policy, we draw to the Committee's attention the concerns raised by the ombudsman for Canada's federal prison system. In his 2014 report to the Minister responsible for that system, the Correctional Investigator of Canada indicated that "upon admission, 80% of federally sentenced male offenders have a substance abuse problem," and further observed:

> The most visible change during my tenure as Correctional Investigator has been the growth in the overall size, complexity and diversity of the offender population. It is not a new observation that some of Canada's minority, vulnerable or disadvantaged groups are disproportionately involved in the criminal justice system. These trends are accelerating within federal prisons. Since March 2005, the federal inmate population has increased by 17.5%. Over the same period, the Aboriginal population grew by 47.4% and Black offenders by over 75%. These groups now comprise 22.8% and 9.8% of the total incarcerated population respectively. The federally sentenced women population has increased 66%, with the Aboriginal women count growing by 112%.[9]

The Correctional Investigator noted that predictable consequences of mass incarceration have materialized, including overcrowding, increases in rates of violence and self-injury in prisons, and increased use of segregation.[10] All of these raise further concerns regarding the right to health, as well implicate breaches of other human rights standards (e.g., regarding cruel, inhuman or degrading treatment).

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the Standing Senate Committee on Legal and Constitutional Affairs, in relation to the Committee's study on Bill C-10 (2012), online: http://www.aidslaw.ca/site/wp-content/uploads/2013/04/Senate-brief_C-10_2012-ENG.pdf.

[8] British Columbia Civil Liberties Association, *More Than We Can Afford: The Costs of Mandatory Minimum Sentencing*, 2014, online: https://bccla.org/our_work/more-than-we-can-afford-the-costs-of-mandatory-minimum-sentencing/.

[9] Office of the Correctional Investigator of Canada, *Annual Report: 2013-2014,* 2014 at p. 2, available at http://www.oci-bec.gc.ca/cnt/rpt/pdf/annrpt/annrpt20132014-eng.pdf.

[10] Ibid.

Third, we note that **discrimination impedes access to health care** – which remains a challenge for people who use drugs as they continue to suffer from stigma and judgmental attitudes by health care professionals[11] and as the federal government has taken active measure to prevent access to evidence-based health services. This includes the enactment in 2015 by Parliament of the so-called *Respect for Communities Act* (Bill C-2, *An Act to amend the Controlled Drugs and Substances Act*), which legislated an unjustifiably onerous application process for an exemption from Canada's drug laws so as to permit the effective operation of supervised injection facilities without risk of criminal prosecution for clients and staff.[12] This legislation has been widely condemned by public health and human rights experts as flying in the face of a previous decision of the Supreme Court of Canada finding that the denial of such an exemption constituted an impermissible, unconstitutional breach of the rights to life, liberty and security of the person of people with addictions needing access to such a health service (the internationally-recognized "Insite" supervised injection site in Vancouver).[13] It is hard to conceive of such barriers being legislated to impede other, evidence-based (and internationally recommended) health services responding to a well-documented public health need. This further reflects the discriminatory measures adopted by the Government of Canada to impede the realization of the highest attainable standard of health in the case of people struggling with addiction (which, as noted above, amounts to discrimination on the basis of disability, including under well-established Canadian anti-discrimination law such as the *Canadian Human Rights Act*).

Rights of Indigenous peoples

Canadian's punitive approach to illicit drugs has had a particularly harsh impact on indigenous peoples, who represent less than 5 per cent of the Canadian population[14] but account for half of all new HIV cases attributed to injecting drug use.[15] Indigenous peoples are also disproportionately represented in prisons where they comprise 23 per cent of the population. Indigenous women represent 33 per cent of all women sent to federal institutions.[16] Moreover, and as reported by the federal Correctional Investigator, Indigenous peoples are more likely to serve more of their sentence behind bars, be held in segregation or with maximum security populations, and be disproportionately prone to self-injury while in prison. This tragic situation is directly linked to current drug policy. As revealed by a research study looking at a sample of Indigenous people enrolled in the Aboriginal Offender Substance Abuse Program of the Correctional Service of Canada (CSC), almost all (96%) indicated that substance use was related to their current offence; 85% reported they were under the influence at the time of their offence.[17] Resources spent on enforcement of Canada's drug laws – including laws that now mandate minimum prison sentences in various circumstances – continue to fuel incarceration and undermine health and human rights, instead of protecting and promoting the health and well-being of Indigenous peoples in Canada.

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[11] L. Van Boekel et al., "Stigma among health professionals towards patients with substance use disorders and its consequences for healthcare delivery: Systematic review," *Drug and Alcohol Dependence* 2013; 131: 23-35.
[12] Canadian HIV/AIDS Legal Network, Canadian Drug Policy Coalition, *An Injection of Reason: Critical Analysis of Bill C-2* (2014), online: http://www.aidslaw.ca/site/an-injection-of-reason-critical-analysis-of-bill-c-2/.
[13] *Canada (Attorney General) v. PHS Community Services Society*, 2011 SCC 44.
[14] Statistics Canada, *Aboriginal Peoples in Canada: First Nations People, Métis and Inuit,* 2011, available at http://www12.statcan.gc.ca/nhs-enm/2011/as-sa/99-011-x/99-011-x2011001-eng.cfm.
[15] Public Health Agency of Canada, *HIV and AIDS in Canada. Surveillance report to December 31, 2013* (2014), online: http://www.phac-aspc.gc.ca/aids-sida/publication/survreport/2013/dec/assets/pdf/hiv-aids-surveillence-eng.pdf.
[16] Office of the Correctional Investigator of Canada, *Annual Report: 2013-2014* (2014), available at http://www.oci-bec.gc.ca/cnt/rpt/pdf/annrpt/annrpt20132014-eng.pdf.
[17] Ibid., p. 43.

III. Issues related to the specific provisions of the Covenant

Article 6 (the right to work), Article 10 (protection of the family, mothers and children), and Article 11 (the right to an adequate standard of living)

Many Canadians have a criminal record because they were once found in possession of drugs, most often cannabis.[18] Having a criminal record can have serious repercussions on individuals' access to housing, employment and ability to travel.[19] Criminal convictions combined with substance use also affect parental rights. According to the Correctional Investigator of Canada, 3 in 4 incarcerated women are also mothers to children under the age of 18. At the time of their arrest, almost two-thirds were single caregivers and over half reported having had experiences with child protection services – often due to problematic substance use, mental health concerns or issues of abuse/neglect. And maintaining family relationships between women and their children throughout their incarceration present many challenges.[20]

Right to health (Article 12): retrogressive measures regarding health goods, services and information

As noted above, pursuant to the adoption in 2007 of a new National Anti-Drug Strategy in Canada, federal funding was diverted away from harm reduction measures (which were excised entirely from the strategy despite their long-standing presence as a key element of a "balanced" approach), in favour of enhancing law enforcement responses to drugs with greater funding. Such action signals a deliberate, retrogressive measure, putting people who use drugs at increased risk of harm. Harm reduction includes such evidence-based health services as **needle and syringe programs** (NSPs) and **supervised consumption services** (SCS), which prevent overdose and the transmission of communicable diseases such as HIV and HCV, and can increase access to treatment and to other health and social services.

The most recent surveillance data indicates that 12.8% of new HIV infections in Canada are attributable to injection drug use.[21] Harm reduction programmes are therefore, essential for protecting the right to health of people who use drugs, yet multiple barriers hinder access to these programs in Canada – including the federal government's active efforts to hinder the introduction of new SCS in Canada (see discussion of Bill C-2 above). Similarly, access to treatment for problematic substance use, including **opioid substitution therapy** (OST), is limited and is generally underfunded across the country[22] and some municipalities have enacted bylaws to prevent the operation of methadone clinics or NSPs, prompting at least one provincial Human Rights Commission to express its concern about this manifestation of disability-based discrimination.[23]

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[18] Centre for Addiction and Mental Health, *Cannabis Framework Policy* (2014), p.6 available at http://www.camh.ca/en/hospital/about_camh/influencing_public_policy/Documents/CAMHCannabisPolicyFramework.pdf.
[19] Ibid.
[20] Office of the Correctional Investigator of Canada, *Annual Report: 2013-2014,* 2014 at p. 46, available at http://www.oci-bec.gc.ca/cnt/rpt/pdf/annrpt/annrpt20132014-eng.pdf.
[21] Public Health Agency of Canada, *HIV and AIDS in Canada. Surveillance report to December 31, 2013* (2014), online: http://www.phac-aspc.gc.ca/aids-sida/publication/survreport/2013/dec/assets/pdf/hiv-aids-surveillence-eng.pdf.
[22] Canadian Drug Policy Coalition, *Getting to tomorrow: a report on Canadian drug policy* (2013), online: http://drugpolicy.ca/report/CDPC2013_en.pdf; A. Klein, *Sticking Points: Barriers to access to needle and syringe programs in Canada* (Canadian HIV/AIDS Legal Network, 2007), online: http://www.aidslaw.ca/site/sticking-points-barriers-to-access-to-needle-and-syringe-programs-in-canada/.
[23] E.g. "Anti-Harm Reduction Bylaw Challenge Accepted By BC Human Rights Tribunal," *Abbotsford Today*, July 18, 2013, available at http://www.abbotsfordtoday.ca/anti-harm-reduction-bylaw-challenge-accepted-by-bc-human-rights-tribunal/; see also various letters from the Ontario Human Rights Commission to several Ontario municipalities expressing concern

Unnecessary barriers to **heroin-assisted treatment** (HAT) for those for whom other treatment options have failed is yet another example of how a punitive, prohibitionist approach to illicit drugs continues to prevent access to evidence-based health services in Canada. Contrary to evidence-based recommendations from her own department (Health Canada), the former federal Minister of Health introduced new regulations criminalizing the prescription of HAT, undermining evidence-based medical practice and denying access to those for whom it had been clinically indicated. Following the launch of a challenge to those new regulations as breaching constitutional rights, a court of first instance, concerned about the harms to the health and security of the person of those denied access to medication issued a temporary injunction in 2014 blocking the harmful regulations from coming into force while the merits of the challenge proceed to a full hearing,[24] but the matter remains unresolved at this time and hence cause for human rights concern about deliberate government action to block access to evidence-based medical treatment.[25]

Guaranteeing **access to medical cannabis** is another example of a constitutional battle that individuals and organizations have been forced to undertake as a result of Canadian drug policy-relying on courts' decisions to safeguard the right to health of people who use drugs is not an acceptable alternative to policy based on human rights, public health and evidence.

While data on the number of people dying of **overdose** in Canada is limited and partial, the available figures indicate that overdose deaths due to medical and non-medical drug use are now a significant source of mortality (e.g., the third leading cause of accidental death in Ontario), with opioid deaths on the rise in recent years in several provinces.[26] Other measures, in addition to supervised consumption services, can be taken to reduce overdose death, such as making naloxone readily available and by reducing barriers to accessing emergency services during a drug overdose. Current policy and legislation hinder these efforts. The criminalization of drug use and possession in Canada also deter witnesses of overdoses from calling emergency services.[27] On a positive front, the newly-appointed federal Minister of Health announced in mid-January 2016 that her department would be taking regulatory steps to ease access to naloxone by allowing use without a prescription.[28] This is a welcome step toward safeguarding the health of people who use drugs and are at risk of fatal opioid overdose, and the Government of Canada is to be commended. But other legislative measures are needed, as indicated here.

Right to health in prison

High rates of incarceration of people who use drugs in Canada, and the extent of unsafe injection drug use in prisons, pose an ongoing threat to the health and safety of prisoners and to public health more generally. However, Canadian prison authorities consistently refuse to implement comprehensive, evidence-based harm

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with discriminatory by-laws or other measures impeding operation of methadone clinics for people with opioid dependence: http://www.ohrc.on.ca/en/search/site/methadone.

[24] See decision of the Supreme Court of British Columbia in *Providence Health Care Society v. Canada (Attorney General), 2014 BCSC* 936, online at: http://bit.ly/YIW0HO.

[25] D. King, "The HAT Injunction, what does it mean?" posted on May 29, 2014, available at http://www.pivotlegal.org/the_hat_injunction_what_does_it_mean.

[26] Canadian Drug Policy Coalition, *Opioid overdose prevention and response in Canada,* 2013; other statistics from coroners' offices and health ministries (obtained by Pivot Legal Society in 2015 and on file).

[27] Ibid.

[28] Health Canada Statement on Change in Federal Prescription Status of Naloxone, January 14, 2016, online: http://news.gc.ca/web/article-en.do?nid=1027679.

reduction services in prisons, contravening the obligation to take steps to realize progressively the right to the highest attainable standard of health.

To date, **prison-based needle and syringe programs** (PNSPs) have been introduced in over 60 prisons of varying sizes and security levels in countries such as Luxembourg, Moldova, Germany, Romania, Spain and Switzerland.[29] Evaluations, including by the Government of Canada's own Public Health Agency,[30] have consistently demonstrated that PNSPs reduce the use of non-sterile injecting equipment and resulting blood-borne infections, do not lead to increased drug use or injecting, reduce drug overdoses, lead to a decrease in abscesses and other injection-related infections, facilitate referral of users to drug treatment programmes, and have not resulted in needles being used as weapons against prisoners or staff.[31] PNSP are supported by the UN's specialized technical agencies[32] and the High Commissioner for Human Rights,[33] as well as the UN Special Rapporteur on torture,[34] as a matter of sound public health policy and human rights. They have also been recommended by the Canadian and Ontario Medical Associations,[35] the Canadian Human Rights Commission[36] and the Correctional Investigator of Canada.[37]

[29] R. Lines et al., *Prison Needle Exchange: Lessons from a comprehensive review of international evidence and experience* (Canadian HIV/AIDS Legal Network, 2006); R. Jürgens, *Interventions to Address HIV/AIDS in Prisons: Needle and Syringe Programmes and Decontamination Strategies* (WHO, UNODC & UNAIDS, 2007); UNODC, *A handbook for starting and managing needle and syringe programmes in prisons and other closed settings*, Advance copy, 2014.

[30] PHAC, *Prison needle exchange: Review of the evidence* (Ottawa: PHAC, April 2006).

[31] Lines et al., op. cit.; Jürgens, op. cit., H. Stöver and J. Nelles, "10 years of experience with needle and syringe exchange programmes in European prisons: A review of different evaluation studies," *International Journal of Drug Policy* 2003; 14: 437-444.

[32] WHO, *WHO Guidelines on HIV Infection and AIDS in Prisons*, 1993; UNODC, WHO and UNAIDS, *HIV/AIDS Prevention, Care, Treatment and Support in Prison Settings: A Framework for an effective National Response* (Geneva/Vienna, 2006); UNAIDS, "Statement on HIV/AIDS in Prisons to the UN Commission on Human Rights at its Fifty-second session, April 1996," in *Prison and AIDS: UNAIDS Point of View*, 1997; UNODC, A handbook for
starting and managing needle and syringe programmes in prisons and other closed settings (Advance copy),

[33] *International Guidelines on HIV/AIDS and Human Rights*, *Consolidated Version*, UN Doc. HR/PUB/06/9, Office of the UN High Commissioner for Human Rights and UNAIDS (Geneva, 2006).

[34] J. Mendez, Interim report to the UN General Assembly of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment [regarding revisions to the UN Standard Minimum Rules on the Treatment of Prisoners), UN Doc. A/68/295 (August 2013), para. 71.

[35] Canadian Medical Association, Resolution 26 of 17 August 2005; Ontario Medical Association, *Improving our Health: Why is Canada Lagging Behind in Establishing Needle Exchange Programs in Prisons? A Position Paper by the Ontario Medical Association*, October 2004.

[36] Canadian Human Rights Commission, Protecting Their Rights: A Systemic Review of Human Rights in Correctional Services for Federally Sentenced Women (Ottawa: Canadian Human Rights Commission, 2003), Recommendation No. 4.

[37] Correctional Investigator of Canada, Annual Report of the Correctional Investigator 2004–2005 (Ottawa: Correctional Investigator Canada, 2004), Annex B at 47. With respect to the right to health in prisons, it should also be noted a recent report by the Correctional Investigator of Canada, obtained under access-to-information legislation, found that health services are inadequately resourced in federal prisons, to the point that newly-admitted prisoners, including those with serious mental health issues, are sometimes being denied prescription medications for 30 days or more while waiting for an assessment by prison physicians. Missing HIV medications or anti-psychotic medications can have serious health consequences; missing pain medication could force prisoners to resort to the use of other, prohibited drugs in an attempt to self-medicate for pain. See: P. White, "New inmates denied medicine due to drug-plan flaw: prison ombudsman," *The Globe & Mail*, 30 April 2015, online: http://www.theglobeandmail.com/news/national/processing-delays-leave-new-inmates-without-prescriptions-for-weeks/article24177961/.

Under international law, prisoners retain all rights except insofar as those are necessarily limited by incarceration.[38] This includes the right to the highest attainable standard of health.[39] Prisoners have a right to a standard of health care equal to that available outside of prisons (the "principle of equivalence"),[40] which necessarily includes preventive measures comparable to treatment and services available in the community.[41] Despite this, while NSPs have been operating in communities across Canada for more than two decades, with funding from various levels of government, no such program operates in a single Canadian prison. A constitutional challenge is proceeding against the Canadian federal government for failing to protect the human rights of prisoners by refusing to implement PNSP in the Canadian federal prison system.[42]

IV. Recommendations

We propose that the Committee recommend that Canada, in keeping with its obligations under the Covenant:

- conduct a review of its national drug law and its National Anti-Drug Strategy, with a view towards a comprehensive series of reforms that, based on the best available evidence, will respect human rights and protect individual and public health;

- ensure a full integration of the principle of non-discrimination to safeguard against systemic discrimination of marginalised groups including Indigenous peoples, people who use drugs, minority groups (including ethno-racial minorities) and people living in poverty;

- revise mandatory sentencing laws and policies as they relate to drug offences, to adequately address the disproportionate impact such measures have on vulnerable groups, including on their right to health;

- remove criminal or other penalties for minor drug offences such as possession for personal use;

- redirect the resources currently dedicated to enforcement of such legislation (with harmful consequences for health) to improving access to a comprehensive series of evidence-based health services for preventing, treating and reducing the harms associated with problematic drug use – including improved access to needle and syringe programs, opioid substitution treatment, prescription of heroin for opioid-dependent persons in accordance evidence-based clinical guidelines, and overdose prevention medications and programs; and

- work with health experts, including civil society groups, to implement equivalent access to harm reduction services for people in Canadian prisons, including prison-based needle and syringe programs.

[38] *Basic Principles for the Treatment of Prisoners*, UNGAOR, 45th Sess., Supp. N 49A, UN Doc A/45/49 (1990), Principle 5.
[39] CESCR, *General Comment 14*, op. cit. As HIV and HCV are potentially fatal diseases, the right to life is also relevant in considering states' obligation to take effective measures to prevent HIV and HCV transmission in prisons: UN Human Rights Committee, *General Comment No. 6: The right to life (Article 6)*, 16th Sess., (1982) UN Doc. HRI\GEN\1\Rev.1 at 6, para 5.
[40] *Basic Principles for the Treatment of Prisoners*, UNGAOR, 45th Sess., Supp. N 49A, UN Doc A/45/49 (1990), Principle 9.
[41] CESCR, *General Comment 14*, op. cit., para. 34.
[42] For more information about the lawsuit, please visit: www.prisonhealthnow.ca.

Submission to the Committee on Economic, Social and Cultural Rights
MACEDONIA
Healthy Options Project Skopje's (HOPS), Coalition Sexual and Health Rights of Marginalized Communities (CSHRMC) and
International Centre on Human Rights and Drug Policy (HRDP)
13 May 2016

I. General information: Economic, social, and cultural rights and drug policy

Macedonia is a party to the three main UN drug control conventions, which aim to control certain psychoactive substances by restricting their supply and demand to medical or scientific purposes. While there arguably exists a certain degree in a State party's approach to implementing these obligations, the treaties require the adoption of restrictive measures towards controlled substances.[1] However, Macedonia must also fulfil its domestic constitutional obligations under the Constitution of the Former Yugoslav Republic of Macedonia[2], as well as those under international human rights law, including the *International Covenant on Economic, Social and Cultural Rights,* which Macedonia has ratified. These human rights obligations bind the state in its response to drugs.

When poorly developed and implemented, drug policies can contribute to an environment where individuals are at increased risk of experiencing violations of their economic, social and cultural rights. The 2008 Law on the Control of Narcotic Drugs and Psychotropic Substances aims to prevent and suppress the misuse of narcotic drugs and psychotropic substances.[3] The requirement to suppress the misuse of drugs has introduced a stricter policy approach that shifts the focus away from addressing health and social problems of people who use drugs, to addressing the 'drug problem' through law enforcement and criminal sanctions. In 2016, this law was amended without inclusive public consultation, to introduce highly restrictive provisions that regulate the medical use of cannabis—which will impact the accessibility and affordability of the drug for medical applications. The law also regrettably introduced criminal sanctions for possession of cannabis, which will effectively criminalise consumers possessing certain amounts of the substance for agricultural, medical and non-medical uses alike.

The criminalisation of drug possession for personal use has contributed to a significant increase in the incarceration of people who use drugs, many who are in need of medical help, not incarceration. The absence of harm reduction programmes in prisons negatively impacts the health of this vulnerable group while in custody. The new amendments to the national drug law that criminalize low-threshold possession will additionally deteriorate the situation for people who use drugs and has worrying implications for minority communities. The previous 2006 - 2012 National Strategy on Drugs called for a scale up in existing harm reduction programmes, broadening the number and regions covered. The new National Strategy on Drugs (2014-2020), is an unfortunate step back, removing all reference to harm reduction.

Information available on public spending on law enforcement, particularly on anti-drugs programmes, is unclear. However, budget monitoring of the programme for health care of people with dependencies

[1] United Nations, Single Convention on Narcotic Drugs (1961), as amended by the 1972 Protocol amending the Single Convention on Narcotic Drugs; United Nations, Convention on Psychotropic Substances (1971); United Nations, Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances (1988).
[2] The Constitution of the Republic of Macedonia, Section II (2).
[3] Official Gazette of the Republic of Macedonia (103/2008; 124/2010; 164/2013; 149/2015; 37/2016 and 53/2016). Law on the Control of Narcotic Drugs and Psychotropic Substances, Article 2.

(including drug dependence) in Macedonia for 2011, 2012 and 2013 demonstrates a consistent decrease in spending with an average annual rate of 14,7%.[4] The Programme for social protection (Daily centres and shelters for non-institutional social protection) includes work with people who use drugs and their families. The budget monitoring of this programme demonstrates that in 2011, 2012 and 2013 only 0,73% of the Programme budget was used for work with people who use drugs and their families.[5] Since 2015 one of the two centres operating since 2005 were closed.

In addition to the above and in light of the Committee's current review of Macedonia's implementation of the International Covenant on Economic, Social, and Cultural Rights, please find below a brief overview of our main concerns related to Canadian drug law and policy.

II. Issues related to the general provisions of the Covenant (art. 1 – 5)

Equality & Non-discrimination

Discrimination, be it direct or indirect, against people on the basis of health condition is prohibited under the Law on the Prevention of and Protection against Discrimination (LPPD).[6] Nevertheless, the practice of discrimination against people who use drugs remains an ongoing and under-reported concern. People who use drugs are criminalised, rigorously pursued by law enforcement, and viewed as 'undesirable' by the broader Macedonian society.[7] Consequently, people who use drugs are a highly stigmatised and vulnerable group. In 2011, almost 97% of Macedonian citizens admitted they would not accept a person who uses drugs as a neighbour and 92,3% reported intolerance toward health institutions for drug treatment, similar intolerance and discrimination has been documented on part of health professionals charged with caring and treating people who use drugs.[8]

There are three particular groups of people who belong to other marginalised groups, but because of their drug use, suffer intersectional discrimination, which undermines their economic, social, and cultural rights: adolescents, women, and ethnic minorities.[9]

Harm reduction services are available to adolescents in exceptional circumstances and consist only of opioid substitution treatment (OST) programs for young people, who receive treatment only sporadically. There are no evidence based drug programmes that can guarantee access to appropriate treatment for people under 18. According to Macedonia's 2014 National Report on Narcotic Drugs, there were only five adolescents who received OST treatment. While a new Directive was issued by the Ministry of Health in 2012 removing age restrictions to access methadone, hospitals are only allowed to admit young people over 18 to drug treatment programmes.[10] These drug treatment centres are the only places legally permitted to prescribe methadone. These restrictive legal and policy barriers effectively exclude a large number of adolescents in urgent need of medical treatment and raises

[4] Dimitrievski V., Jankuloski H., Stefanov S. The possibilities for sustainable financing of the harm reduction programmes from the Budget of the Republic of Macedonia, 2015.
[5] Dimitrievski V., Jankuloski H., Stefanov S. The possibilities for sustainable financing of the harm reduction programmes from the Budget of the Republic of Macedonia, 2015
[6] The Law on the Prevention of and Protection against Discrimination (the LPPD), Official Gazette of RM, no. 50, 8 April 2010. The LPPD can be found on this following link: https://www.ecoi.net/file_upload/1226_1317212111_fyrom-law-on-protection-against-discrimination-2010-en.pdf
[7] Simoska E., Gaber N. and others. How inclusive is the Macedonian Society, 2008
[8] Klekovski S., Krzalovski A. Stojanova D. Macedonian Societal Values, MCIC 2011.
[9] Dimitrievski V., Boskova N., Improvement of the Quality of Drug Dependence Treatment Programms in Skopje: Assessment of the Quality of Drug Dependence Treatment Programs with A Community-based Monitoring by Persons Treated for Drug Dependence, 2012, p.
[10] Official Gazette of the Republic of Macedonia no. 36/2012; see also Statute of Hospital, Macedonia

questions around Macedonia's compliance to a number of national legal protections against discrimination and the right to health, including Article 3 of the LPPD, and under Article 2 (2) and 12 of the ICESCR.

Discrimination against women who use drugs is reflected by the lack of gender-sensitive planning and programming of drug dependence treatment. The current National Drug Strategy fails to incorporate a gender perspective and fails to consider the structural dimensions of women's vulnerability to HIV transmission.[11] Commitment to gender-sensitive policy serves as a mere principle without specific measures and activities to be implemented. There is no explicit obligation for the collection and analysis of gender-sensitive data.[12] The lack of available and accessible gender-sensitive drug dependence treatment has discouraged women from accessing treatment, especially in treatment centres where most of the clients are men.[13]

The Roma of Macedonia are a community that has been historically marginalised and excluded in all aspects of social, political, and economic life. According to the 2006 – 2012 National Drug Strategy, Roma people who use drugs are an insufficiently analyzed group.[14] Within Macedonia's population of people with no citizenship, 23% are Roma.[15] Without citizenship status, individuals have no access to social services and health insurance. In the context of Roma people who use drugs, this situation leads to their inability to access drug dependence treatment, despite a significant number of Roma reportedly in need of services each year.[16] An example of the structural challenges this community faces is the municipality of Shuto Orizari, which has the highest population of Roma. To date, and despite donor commitments from the international community, Shuto Orizari has no available drug dependence treatment or services.[17] More generally, there is evidence to suggest that when Roma people enter drug dependence treatment in health care settings, they are exposed to higher rates of violence from other patients.[18]

Through these examples, there is clear evidence of entrenched discrimination towards these groups, made more vulnerable as their status as women, adolescents, or Roma intersects with their status as a person who uses drugs. The Government of Macedonia has systematically failed to take necessary action to protect these groups from degrading treatment at the hands of private and public actors. Likewise, the legal framework currently in place fails to respect their entitlement to equal treatment, with punitive, restrictive, and discriminatory laws and policies around drugs and drug treatment hindering availability and equal access to services entitled to these groups under articles 2,3,10, and 12 of the ICESCR.[19] The decision to make services available to the community of people who use drugs is treated in Macedonia as a political decision, often based on public support (or lack thereof) from the community. Ensuring that all people are able to access necessary health services regardless of their

[11] Badarevski B., Savovska M, Dimitrievski V. Assessment of gender related issues and their connection to the risk of HIV/AIDS and the barriers conditioning the equal access to adequate HIV/AIDS prevention and treatment services, 2012, p. 11 – 13.
[12] Badarevski B., Savovska M, Dimitrievski V. Assessment of gender related issues and their connection to the risk of HIV/AIDS and the barriers conditioning the equal access to adequate HIV/AIDS prevention and treatment services, 2012, p. 21.
[13] Badarevski B., Savovska M, Dimitrievski V. Assessment of gender related issues and their connection to the risk of HIV/AIDS and the barriers conditioning the equal access to adequate HIV/AIDS prevention and treatment services, 2012, p. 23.
[14] Ministry of Health. National Drug Strategy 2006-2012, December 2006.
[15] Dimitrievski V., Improving drug using Romas' right to access to social and health services. Skopje: HOPS, 2011, p. 9.
[16] Of the people who use drugs accessing harm reduction programmes in Skopje, 16% of the total number are Roma
[17] Dimitrievski V., Boskova N., Improvement of the Quality of Drug Dependence Treatment Programms in Skopje: Assessment of the Quality of Drug Dependence Treatment Programs with A Community-based Monitoring by Persons Treated for Drug Dependence, 2012, p. 21.
[18] Dimitrievski V., Improving drug using Romas' right to access to social and health services. Skopje: HOPS, 2011, p. 20.
[19] Also see LPPD, Art. 5

status must not be viewed as a policy option. In Macedonia, it is a legal obligation under articles 12 and 2 of the ICESCR.

Further, The LPPD does not achieve any progress in this field and the evaluation of the implementation of the LPPD does not propose any changes in the future. The latest evaluation of the LPPD by the Ministry of Labour and Social Policy refers only to the campaigns on elimination of stigma and discrimination against people who use drugs organized by NGOs. The law lacks an explicit framework that both guarantees and recognises the state's obligations to protect people who use drugs from all forms of discrimination. As a State party of the ICESCR, Macedonia has an immediate obligation to ensure that the realisation of economic, social and cultural rights occurs without discrimination.[20] This obligation requires the State to protect, promote and fulfil the the guarantees provided for within the Covenant without discrimination of any kind, including on basis of health or social status, including a person who uses drugs or a person who is experiencing drug dependence.[21]

III. Issues related to specific provisions of the Covenant (art. 6 – 15)

The right to health (Article 12)

According to the available data, there are approximately 10,300 people living with opioid dependence in Macedonia. However, only around 1,750 of them are documented as receiving treatment.[22] More than 80% of people who are reported to be opioid dependent in Macedonia have no access to drug dependence treatment. Likewise, harm reduction coverage is limited in scale and geographic scope, with only 16 harm reduction programmes country-wide, of which 25% are concentrated in the capital.

In Macedonia, access to treatment services for drug dependency is guaranteed under the 2012 Law on Health Insurance for the first 30 days of treatment.[23] However, drug treatment and harm reduction is not included in the core package of essential medical interventions guaranteed after the 30-day period and individuals in need of ongoing treatment face additional barriers to access, including user fees and denial of medication in the event of relapse. Barriers to access are further heightened for vulnerable groups including women, adolescents, and ethnic minorities. The lack of data disaggregation is a further impediment to understanding and ensuring accessible, available, acceptable and quality health service for the community of people using drugs and in need of medical care in Macedonia.

The right to health under the Covenant obligates State parties to ensure health services, goods, and facilities be made available in adequate numbers and provided without discrimination. The Committee has articulated health services to include drug dependence treatment and harm reduction interventions such as opioid substitution therapy, needle and syringe exchange programmes, and access to naloxone for the prevention of opiate overdose.[24] The right also requires these health services to be accessible

[20] International Covenant on Economic, Social and Cultural Rights, UNTS Vol. 993, P. 3, 16 December 1966, Article 2.
[21] 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
[22] Dimitrievski V., Cvetković I., Dekov V., Macedonia: Community monitoring and advocacy in highly stigmatizing circumstances, 2014
[23] Law on Health Protection, Official Gazette of the Republic of Macedonia No. 3/2014.
[24] UN Committee on Economic, Social and Cultural Rights. 'Concluding Observations on Ukraine' (E/C.12/UKR/CO/6) 2014; UN Committee on Economic, Social and Cultural Rights, 'Concluding Observations on Uzbekistan' (E/C.12/UZB/CO/2) 2014; UN Committee on Economic, Social and Cultural Rights. 'Concluding Observations on Belarus' (E/C.12/BLR/CO/4-6) 2013; UN Committee on Economic, Social and Cultural Rights. 'Concluding Observations on Mauritius' (2010) E/C.12/MUS/CO/4; UN Committee on Economic, Social and Cultural Rights. 'Concluding Observations on the Russian Federation' (2011) E/C.12/RUS/CO/5

geographically for all populations, particularly for vulnerable and marginalised groups.[25] Accessibility also means prevention, harm reduction and drug treatment services must be affordable for the population, with particular attention to the most vulnerable groups. Importantly, drug prevention, harm reduction, and treatment services must be delivered in a manner that is acceptable within the framework of medical ethics and designed to address the unique needs of the current population of people who use drugs. This must also include sensitivity towards gender and the unique needs and evolving capacities of adolescents. The right to health also requires that health services to address drug use be of sufficient quality, based on scientific evidence, and delivered by health professionals with adequate training and skills to provide care to this vulnerable population compassionately, ethically, without judgement.

While the fulfilment of the right to health is subject to progressive realisation and resource constraints, some obligations must be implemented immediately including non-discrimination and other core obligations. Macedonia has a core obligation to adopt a national public health strategy, which addresses the health of the entire population, with particular attention to marginalised groups, including people who use drugs.[26] Another core obligation is the requirement to take measures to prevent, treat and control epidemics.[27] This in turn, demands immediate commitment of resources to the delivery of harm reduction and treatment programmes, which have been proven effective in the prevention of HIV/AIDS transmission.

The current scale and coverage of harm reduction and drug treatment services across the country indicates Macedonia is currently not in compliance with their obligations under the Covenant. The case of Shuto Orizari is a clear example of the need to remind Macedonia that providing health care and harm reduction services is a legal obligation and must not be treated as a policy decision based on popularity. As the evidence has suggested above, there is an immediate need to address the poor quality of health service provision through better training of health care professionals charged with the care and treatment of people who use drugs.[28] The current national health strategy, which only guarantees 30 days of access to drug treatment fails to comply with the Macedonia's core obligation to address infectious disease transmission.[29]

The lack of data on the community of people who use drugs in Macedonia, specifically that is disaggregated by age, sex and ethnic background presents one of the biggest challenges to promoting the rights of people who use drugs.[30] Without adequate data, States lack evidence to inform health policy, identify gaps, and support the allocation of appropriate resources. Without making this data publicly available, Macedonia is unaccountable in relation to their obligations under the Covenant. The lack of disaggregated data, further renders marginalised groups such as the Roma, adolescents, and women invisible.[31]

In light of the issues presented above, we wish to make the following recommendations:

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[25] CESCR, General Comment No. 14: The Right to the Highest Attainable Standard of Health (Article 12 of the Covenant), 11 August 2000, UN Doc. E/C.12/2000/4, para. 12.
[26] CESCR, General Comment 14, para. 43(f).
[27] [27] CESCR, General Comment 14
[28] Dimitrievski V., Cvetković I., Dekov V., Macedonia: Community monitoring and advocacy in highly stigmatizing circumstances, 2014
[29] Programme for protection of the population against HIV/AIDS in the Republic of Macedonia for 2016. http://www.fzo.org.mk/WBStorage/Files/PROGAMA_ZA_ZDRAVSTVENA__ZASTITA_NA_NASELENIETO_OD__HIV__SIDA_VO_REPUBLIKA_MAKEDONIJA_ZA_2016_GODINA.pdf
[30] State of the World's Children, Adolescence An Age of Opportunity, UNICEF 2011
[31] Committee on the Elimination of Discrimination against Women, Concluding Observations: Macedonia, CEDAW/C/MKD/CO/4-5, 2013, para. 33

- Commit to transparency related to Macedonia's public spending on addressing issues related to drug use and enforcement. It is recommended that Macedonia make provisions in law that require the collection of disaggregated public health and epidemiological data around drug use and drug law enforcement to adequately understand resource investment and gaps.
- Take concrete, targeted measures to fully implement the LPPD in accordance with obligations under the ICESCR, which fully recognises the unique needs of the community of people who use drugs in Macedonia. This should include:
    - An independent study to examine the unique needs of the Roma population currently affected by drug use and barriers to accessing goods and services to treat and address related harms associated with drug use
    - Scale up availability of evidence-based treatment and harm reduction services for adolescents
    - Remove legal barriers to drug treatment service and access to OST for adolescents including parental consent and other onerous qualification criteria. Additionally, take steps to reconcile national directives on access to methadone to ensure adolescents have real access to this service at hospital treatment centres.
    - Commit resources towards the disaggregation of drug use and services data, with a particular focus on ethnicity, gender, children—including adolescents aged 10-19, to better understand the needs and barriers to health services of this vulnerable population
- Conduct a comprehensive reform of the current national drug strategy, which fully integrates a human rights-based approach to drug policy and includes:
    - Provisions for the immediate scale up of harm reduction services throughout the country, including in prisons, to include OST, needle exchange, and overdose prevention.
    - Budgetary allocation for the progressive realisation of these services to be delivered without discrimination
    - Disaggregated data collection and public dissemination
    - Removal of criminal sanctions regarding cannabis possession

International Centre on Human Rights and Drug Policy and Swedish Drug Users Union Submission on Sweden's Sixth Periodic Report to the Committee on Economic, Social and Cultural Rights

May 2016

Issues raised by the Swedish Drug Users Union and the International Harm Reduction Association in relation to Sweden's fifth periodic report (2007/2008)

In 2007 the Swedish Drug Users Union became the first organisation of people who use drugs to present a shadow report to the Committee (or any human rights treaty body).

At that time concerns were raised with the Committee about:

- Data gaps: The lack of a population size estimate of people who inject drugs in Sweden
- HIV and Hepatitis C incidence and prevalence rates
- The existence of only two needle and syringe programmes (NSP) in the country
- Restrictions on access to opioid substitution therapy (OST) in the community, and the absence of OST in prisons.
- The lack of adequate responses to overdose deaths

Outcomes of the 2007/2008 reporting process

The Committee took on board some of the NGOs' concerns in its list of issues to Sweden. It requested, at para 29, that the State party:

> *Please provide disaggregated data concerning the incidence of HIV/AIDS, in particular regarding the coincidence of drug use and HIV/AIDS and indicate how successful harm reduction measures have been (such as needle exchange programmes), whether they are foreseen to be scaled up, and whether such programmes are foreseen in detention facilities?*

Regrettably, in addition to an inadequate response from Sweden, this was not taken further in the meeting with the delegation or in Concluding Observations.

Developments in Sweden 2008-2016

<u>Welcome developments</u>

There have been important, positive developments with regard to policies relating to drug use, drug related harms and the realisation of the right to health in Sweden since the last reporting period. In particular:

- The statutory waiting period of two years for access to OST following the first diagnosis of opiate dependence has been removed. It is now at the discretion of the physician to prescribe.[1]

- There is no longer a possibility of exclusion from OST for a failed drug test.[2]

- OST can now be prescribed if a person is mandated for drug treatment.[3]

- Since 2008 three new needle and syringe programmes have been initiated (over four sites). A programme has been announced for Gothenburg, the second largest city. This has been due to a concerted effort of the new government, given that a major barrier to new NSP was that health budgets are controlled by local authorities, some of which are resistant. There are plans to amend the needle exchange legislation (2005) to remove the ability of municipal authorities to veto the initiation of new services. This would ease considerably the scale up of services. The amendment also aims to reduce the age restriction on access to such services from 20 to 18.[4]

- Sweden has gradually increased its support for organisations of people who use drugs, including: increased funding, inclusion of people who use drugs on key health panels, and visible activities at the UN to encourage other States to follow suit.

- The government has also expressed publicly its sincere concern and desire to address the overdose and hepatitis C situations set out below. A naloxone programme has been announced.[5]

Issues of concern

Remaining data issues

Since the last reporting period there remains no reliable population size estimate of people who inject drugs in Sweden. The estimates we have are both old and unreliable. This is a considerable impediment to appropriate assessment of service need, budget analysis and to the control of communicable diseases.

Opioid Substitution Therapy

OST remains almost entirely absent in prisons, though some people in prison are on this form of treatment. While there are relatively low numbers of people being sentenced to prison for their drug use, a high proportion of people in prison do use drugs. OST cannot be initiated in prisons, and on the discretion of a physician it can be discontinued upon entry into prison. In 2008 it was reported to

[1] https://www.socialstyrelsen.se/SiteCollectionDocuments/Foreskrifter-och-allmanna-rad-om-lakemedelsassisterad-behandling-vid-opioidberoende-remissversion.pdf

[2] *Ibid*

[3] *Ibid*

[4] European Monitoring Centre for Drugs and Addiction, Country Overview: Sweden http://www.emcdda.europa.eu/country-data/harm-reduction/Sweden; Goteburg Daily, 'Health Minister Fights for Needle Exchange Programs', Feb 2015 http://www.goteborgdaily.se/health-minister-fights-for-needle-exchange-programs

[5] 2014 National Report (2013 data) to the EMCDDA by the Reitox National Focal Point (2014, Public Health Agency of Sweden)

the Committee that the European Committee for the Prevention of Torture (CPT) had challenged the lack of OST in Swedish prisons. The CPT repeated this concern in its most recent visit to Sweden in 2015.[6]

Needle and Syringe Programmes

While there has been some progress, the coverage of needle and syringe programmes in Sweden is very poor, with only six sites in the country. They are inaccessible to a great many people who inject drugs. In addition they are open only during working hours and those under the age of 20 cannot attend.[7]

While needle and syringe programmes alone cannot address the Hepatitis C epidemic (see below) it is widely acknowledged that high quality, properly stocked programmes are absolutely essential in any public health response to it. [8]

In addition, the Stockholm needle exchange has shown in its first years that it is reaching people that had previously not been in contact with healthcare because of their injecting drug use. Such services fill an important gap in social care and contribute to the effective realisation of their right to the highest attainable standard of health.[9]

In 2006 the UN Special Rapporteur on the Right to Health visited Sweden and recommended national scale up of NSP.[10] There is desire to see this happen but it is very slow.

Hepatitis C

The situation with regard to HCV in Sweden remains very serious. With one of the highest prevalence rates in Europe, it is estimated that 80% - 90% of people who inject drugs are infected with HCV.[11] This requires widespread HCV testing and treatment, as well as the high coverage of OST and the considerable scale up of needle and syringe programmes to address.

Overdose deaths

It was reported to the committee that approximately 135 people died from overdose in Sweden in 2007. This has *increased considerably* and, while the numbers are unclear due to the ways in which deaths are recorded, it is thought that the total is closer to 600 per year. Sweden now has one of the highest rates of overdose mortality in Europe. This has become a crisis in the country.[12]

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[6] Report to the Swedish Government on the visit to Sweden carried out by the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT) from 18 to 28 May 2015, paras 79-80; http://www.cpt.coe.int/documents/swe/2016-01-inf-eng.pdf

[7] European Monitoring Centre for Drugs and Addiction, Harm Reduction Overview: Sweden http://www.emcdda.europa.eu/country-data/harm-reduction/Sweden

[8] Vickerman, P; Martin, N; Turner, K; Hickman, M; (2012) *Can needle and syringe programmes and opiate substitution therapy achieve substantial reductions in HCV prevalence? Model projections for different epidemic settings.* Addiction (Abingdon, England)

[9] 'Health Minister backs more needle exchanges' http://www.thelocal.se/20150217/easier-needle-exchange-backed-by-health-minister

[10] 'Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health: Mission to Sweden' (2007) A/HRC/4/28/Add.2

[11] European Monitoring Centre for Drugs and Addiction, Harm Reduction Overview: Sweden http://www.emcdda.europa.eu/country-data/harm-reduction/Sweden

[12] European Monitoring Centre for Drugs and Drug Addiction (2014) 'Country overview: Sweden – Drug-induced deaths and mortality among drug users'

Naloxone is an effective medicine for reversing opiate overdose and when deployed it saves lives. A programme has very recently been announced, but today naloxone is not widely distributed, though it is available to paramedics. In order to save lives widespread distribution is needed, *including through peer distribution to ensure that people who use drugs can respond immediately when friends overdose*.

In addition, the evidence for the effectiveness of OST in reducing overdose mortality is clear. This is particularly important in prisons, where OST remains extremely limited.[13] People who use opiates are at very high risk upon release from prison.

Additional concerns: Budgetary allocation

At the last assessment in 2002, it was estimated that Sweden spends approximately 75% of its drug policy budget on law enforcement, 24-25% on prevention and treatment and less than 1% on harm reduction.[14] This has likely changed to some degree, but remains still entirely disproportionate for the progressive realisation of the right to heath. A large proportion of police resources is spent on low-level possession and sales offences.

Developments in the Committee's jurisprudence since 2008

While the Committee did not take up these issues in its 2008 Concluding Observations on Sweden it has since then increased its attention to issues of drug use and drug related harm. The following issues have been taken up:

- Needle and syringe programmes (Mauritius 2010, Russia 2011)
- Opioid substitution therapy (Poland 2009, Kazakhstan 2010, Mauritius 2010, Russia 2011)
- Overdose prevention (Russia 2011)
- Youth-focused harm reduction services (Mauritius 2010)
- Specific protections for women at risk (Mauritius 2010)
- Prison OST and NSPs (Ukraine 2007 and Mauritius 2010 respectively)
- Law reform to facilitate harm reduction (Mauritius 2010, Russia 2011)

Recommendations

We encourage the Committee to welcome the above developments and to ask questions of the Swedish delegation on the above issues of concern. We also encourage the Committee to make these specific time-bound recommendations with a view to the next periodic report from the state party:

- Conduct research to develop a population size estimate for people who inject drugs.

- Continue to work to scale up needle and syringe programmes, in line with international best practice standards. In this regard, age restrictions should be removed entirely, and opening

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[13] European Monitoring Centre for Drugs and Addiction, Harm Reduction Overview: Sweden http://www.emcdda.europa.eu/country-data/harm-reduction/Sweden

[14] M. Ramstedt (2006), 'What drug policies cost: estimating drug policy expenditures in Sweden, 2002: work in progress', Addiction 101, pp. 330–8; European Monitoring Centre for Drugs and Addiction, Public Expenditure Overview: Sweden http://www.emcdda.europa.eu/countries/sweden

hours should accommodate the fact that people who require services have jobs, children and other commitments that can preclude access.

- Ensure access to OST in prisons equivalent to that available in the community.

- Work to ensure that all people who inject drugs are offered testing for hepatitis C and offered treatment if they test positive.

- Ensure the widespread distribution of naloxone to help to reduce the mortality from opiate overdose in the country.

- In line with article 2 and with a view to the progressive realisation of the right to health, rebalance budgetary allocation in drug policy to ensure proportionate expenditure on harm reduction, prevention and treatment versus enforcement.

Submission to the Committee on Economic, Social and Cultural Rights
THE REPUBLIC OF THE PHILIPPINES

The Asian Network of People who Use Drugs (ANPUD)[1], The International Network of People who Use Drugs (INPUD)[2],
The International Centre on Human Rights and Drug Policy (HRDP)[3]
August 29 2016

I. General information: Economic, social, and cultural rights and drug policy

The Philippines is a party to the three main UN drug control conventions, which aim to control certain psychoactive substances by restricting their supply and demand to medical or scientific purposes. While there arguably exists a certain degree of flexibility in a State party's approach to implementing these obligations, the treaties require the adoption of restrictive measures towards controlled substances.[4] However, the Philippines must also fulfil its domestic constitutional obligations under the Constitution of the Republic of the Philippines[5], as well as those under international human rights law, including the *International Covenant on Economic, Social and Cultural Rights,* which the Philippines has ratified. These human rights obligations bind the state in its response to drugs.

When poorly developed, drug policies can contribute to an environment where individuals are at increased risk of experiencing violations of their economic, social and cultural rights. The Comprehensive Dangerous Drugs Act of 2002 aims to prevent and suppress the misuse of narcotic drugs and psychotropic substances, including the penalisation of both personal possession and use of such substances.[6] The requirement to penalise the misuse of drugs has translated into a highly punitive policy approach in the country that includes compulsory drug treatment, heavy policing and mass-incarceration.[7] The punitive focus has displaced the needed investment in public health measures, with inadequate and, in many cases, unscientific treatment options and an entirely absent national harm reduction strategy and programme. The populist political environment that supports this ineffective and disproven means to address drugs in the country has exacerbated human rights abuses, including violations of economic, social and cultural rights on a scale that is both widespread and systemic.

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[1] http://anpud.org/
[2] http://www.inpud.net/
[3] http://www.hr-dp.org/
[4] United Nations, Single Convention on Narcotic Drugs (1961), as amended by the 1972 Protocol amending the Single Convention on Narcotic Drugs; United Nations, Convention on Psychotropic Substances (1971); United Nations, Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances (1988).
[5] The Constitution of the Republic of the Philippines, ratified 2 February 1987
[6] Official Gazette, Republic Act No 10640, The Comprehensive Dangerous Drugs Act of 2002 http://www.gov.ph/2014/07/15/republic-act-no-10640/
[7] Dolan, K. et al. 2014. *HIV, hepatitis B, hepatitis C and syphilis among inmates in Cebu City jails, Philippines: seroprevalence and risk behaviors*.

In 2016, the newly elected President, Rodrigo Duterte, vowed to crack down on people who use and sell drugs to address the country's 'drug problem'. The highly punitive rhetoric, which has included calls to 'shoot on sight' people who use and sell drugs, has been proceeded by prodigious levels of extrajudicial killings and violence towards those suspected of drug-related activity, by both armed vigilantes and police forces. As of the date of this submission, almost 1,900 people have been murdered as a result of this campaign[8]. The severity of this violent campaign uncomfortably parallels the 2003-2004 state-sanctioned war on drugs in Thailand where more than 2,000 individuals were murdered.[9] As in Thailand, those targeted in the Philippines are mainly poor individuals suspected of drug dealing or drug use, and to date, the killings are carried out with absolute impunity.[10]

The extrajudicial killing of people suspected of drug use has also led to thousands of individuals turning themselves in for drug "treatment" in fear for their lives.[11] This punitive tactic uses coercion and violence to compel people to seek health treatment. The increase numbers of people surrendering to "treatment" also places a strain on the existing, weak treatment infrastructure across the country. In the wake of this violent turn in the government's crusade against drugs, several bills have been hastily drafted and proposed by the Senate to increase Presidential authority in handling the country's drug issue and to ramp up enforcement and compulsory drug rehabilitation centres. These proposals, if passed, will further fuel the existing punitive policy environment and give legislative support to the President's violent, highly condemned, anti-drugs campaign.[12] However, there are early signs that an alternative bill—which would introduce harm reduction and human rights into a public health based approach to drug policy—could be introduced to counter these punitive proposals and redress the systemic abuses currently taking place. The political weight such a progressive proposal might carry remains to be seen.

In addition to the above and in light of the Committee's current review of the Philippine's implementation of the International Covenant on Economic, Social, and Cultural Rights, please find below a brief overview of our main concerns related to Filipino drug law and policy.

II. Issues related to the general provisions of the Covenant (art. 1 – 5)

[8] BBC News http://www.bbc.com/news/world-asia-37162323

[9] Report of the Special Rapporteur on Executions, Summary of cases transmitted to governments and replies received (24 march 2004) E/CN.4/2004/7/Add.1, paras 557-558

[10] Press Release by UN Special Rapporteurs on the right to health and summary, arbitrary or extra-judicial executions "UN Experts urge the Philippines to stop unlawful killings of people suspected of drug-related offenses" (August 2016)
http://www.ohchr.org/EN/NewsEvents/Pages/DisplayNews.aspx?NewsID=20388&LangID=E

[11] CNN "Dead of Alive: Is the Philippines War on Drugs Out of Control", 4 August 2016, http://edition.cnn.com/2016/08/03/asia/philippines-war-on-drugs/ (last accessed: Aug. 26, 2016)

[12] Press Release by UN Special Rapporteurs on the right to health and summary, arbitrary or extra-judicial executions "UN Experts urge the Philippines to stop unlawful killings of people suspected of drug-related offenses" (August 2016)

Equality & Non-discrimination

In the Philippines, there is no national comprehensive anti-discrimination legislation to protect vulnerable groups (including people who use drugs) from any type of discrimination. This includes discrimination on the basis of health condition, understood by the Committee to include drug dependence.[13] The practice of discrimination against people who use drugs remains a significant and under-reported concern in the country. The recent spate of murders of people suspected of using drugs by police forces and armed vigilante groups chillingly brings this issue out of the shadows. The widespread murder of drug suspects arises from an uneasy history of extrajudicial killings in the Philippines, a tactic used to cleanse communities of 'undesirables', the majority of whom are poor, young adults without access to social protection or socio-economic opportunities, including drug suspects.[14] This history, in combination with the existing legal framework to address drug possession, trafficking, and consumption has served as a fertile breeding ground for the relentless killings across the country since June. Filipino drug laws and policies have been entirely law enforcement focused, entrenching punishment, intolerance, and violence towards drug suspects, including people who use drugs. Despite constitutional protection of the right to health, people seeking drug treatment in the country are not provided with affordable access to treatment as their condition is viewed as "voluntary" under the National Health Insurance Act of 1995.[15] In light of the above and considering the absence of comprehensive anti-discrimination laws, the government of the Philippines has failed to uphold their article 2 obligations under the Covenant. Importantly, the government of the Philippines has failed to ensure these vulnerable individuals have access to health and social services, and as we are witnessing today, failed to secure justice and their personal safety.

III. Issues related to specific provisions of the Covenant (art. 6 – 15)

The right to health (Article 12)

According to the Dangerous Drugs Board, there are approximately 1.3 million people who use drugs in the Philippines, with methamphetamine, cannabis and inhalants being the top illicit drugs of concern.[16] As of the date of this submission, thousands of people have surrendered to "treatment" and are likely to increase in light of recent events. However, as of 2014, only around 4,392 or 0.004% of people who use drugs are documented as receiving treatment.[17]

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[13] General Comment 14, para. 36

[14] *Report of the Special Rapporteur on Extrajudicial, Summary or Arbitrary Executions, Philip Alston : addendum : mission to Philippines*, 16 April 2008, A/HRC/8/3/Add.2

[15] National Health Insurance Act of 1995, section 11 http://www.gov.ph/2013/06/19/republic-act-no-10606/

[16] http://www.ddb.gov.ph/newsroom/46-sidebar/58-facts-on-drugs

[17] Dangerous Drug Board, Office of the President, 2014 statistics, http://www.ddb.gov.ph/research-statistics/statistics/45-research-and-statistics/246-2014-statistics

While the Dangerous Drugs Act includes provision for a minimum of one treatment facility in each of the country's 81 provinces, there are currently only 45 inpatient drug treatment centres across the country, including 19 that are run by the government. There are extremely limited outpatient and community-based drug dependence treatment services available or accessible, which further reflects the significant gap in the country's approach to evidence informed treatment. Harm reduction services are not available anywhere in the country. Nationwide, fewer than 300 medical professionals are currently certified to clinically assess people who surrender to authorities.

The Department of Health has set up a national task force to develop a comprehensive algorithm to assess and meet the needs of those who surrender, with significant budget allocations to support the expansion of drug dependence treatment nationwide. However, without stronger commitment to ensure progress away from the out-dated, substandard quality in-patient treatment centres, in favour of community based models, any such expansion could further come into conflict with the right to health. In parallel, proposals from the office of the President have been advanced to set up new drug treatment centres within military camps and jails.[18] Coercion and compulsory drug treatment have been widely condemned by the international community and are routinely highlighted as a violation of the right to health by the Committee.

More than 40% of people who are reported to be opioid dependent in the Philipinnes are also HIV positive, one of the highest rates in the region.[19] HCV rates among people who inject drugs in the Philippines have been estimated at 70%.[20] The Philippines has the fastest growing HIV infection rate amongst people who inject drugs in the region.[21] Yet, the Dangerous Drugs Act criminalises possession and distribution of safe injecting equipment. In 2010, the Global Fund recommended that the Philippines revise its criminal laws to enable a comprehensive HIV response for people who inject drugs, which includes decriminalising safe injecting equipment.[22] A small pilot programme was launched from 2013-2015, which, with a legal exemption from Section 12 of the Dangerous Drugs Act, enabled a needle and syringe exchange programme in Cebu City. The exchange programme was closed after only five months time, despite early indications of successful health outcomes.[23]

As made reference to earlier, in the Philippines, individuals have two options for treatment: unaffordable and poor quality voluntary treatment or compulsory drug detention. Access to the limited and poor quality treatment services for drug dependency is explicitly excluded

[18] see DDB statements for August here: http://www.ddb.gov.ph/
[19] Global State of Harm Reduction 2015, p 33 https://www.hri.global/files/2015/02/16/GSHR2014.pdf
[20] Harm Reduction International. 2014. G*lobal State of Harm Reduction*.
[21] Stone K. The Global State of Harm Reduction 2014. London: Harm Reduction International; 2014
[22] Office of the Inspector General. 2010. Audit Report on Global Fund Grants to the Philippines. (see Recommendation #25, paragraph 267
[23] Pascal Tanguay, Evaluation of Harm Reduction Service Delivery in Cebu City, Philippines (2013 –2015) World Bank, 2016 http://documents.worldbank.org/curated/en/413401468197106125/pdf/106126-WP-P132149-PUBLIC-ACS.pdf

under the National Health Insurance Act of 1995, making services unaffordable to low income communities.[24] Separately, under the Dangerous Drugs Act, compulsory drug treatment is proscribed for certain offenses, including for minors. In the wake of the current state-sanctioned violence towards drug suspects, those surrendering for "treatment" are being channelled through the criminal justice system with the only treatment options available being compulsory, within closed settings (jails and potentially military camps), with no scientific evidence-base to support its effectiveness.

The right to health under the Covenant obligates State parties to ensure health services, goods, and facilities be made available in adequate numbers and provided without discrimination. The Committee has articulated health services to include community-based drug dependence treatment and harm reduction interventions such as opioid substitution therapy, needle and syringe programmes, and access to naloxone for the prevention of opiate overdose.[25] The right to health also requires these health services to be accessible geographically for all populations, particularly for vulnerable and marginalised groups.[26] Accessibility also means health services to address drug use must be affordable for the population, with particular attention to the most vulnerable groups. Importantly, these services must be delivered in a manner that is acceptable within the framework of medical ethics and designed to address the unique needs of each individual who uses drugs. This includes providing drug related health interventions in a voluntary manner, with the informed consent of the individual. The right to health also requires that health services to address drug use be of sufficient quality, based on *scientific evidence*, and delivered by community experts and health professionals with adequate training and skills to provide care to this vulnerable population compassionately, ethically, without judgement.

While the fulfilment of the right to health is subject to progressive realisation and resource constraints, some obligations must be implemented immediately including non-discrimination and other core obligations. The Philippines has a core obligation to adopt a national public health strategy, which addresses the health of the entire population, with particular attention to marginalised groups, including people who use drugs.[27]

The absence of harm reduction and community-based, voluntary drug treatment services indicates the Philippines is currently not in compliance with their obligations under the Covenant. The highly punitive means to address drug use, including through compulsory treatment or the current climate of violence and coercion indicates an urgent need to reform

[24] National Health Insurance Act of 1995, section 11
[25] UN Committee on Economic, Social and Cultural Rights. 'Concluding Observations on Ukraine' (E/C.12/UKR/CO/6) 2014; UN Committee on Economic, Social and Cultural Rights, 'Concluding Observations on Uzbekistan' (E/C.12/UZB/CO/2) 2014; UN Committee on Economic, Social and Cultural Rights. 'Concluding Observations on Belarus' (E/C.12/BLR/CO/4-6) 2013; UN Committee on Economic, Social and Cultural Rights. 'Concluding Observations on Mauritius' (2010) E/C.12/MUS/CO/4; UN Committee on Economic, Social and Cultural Rights. 'Concluding Observations on the Russian Federation' (2011) E/C.12/RUS/CO/5
[26] CESCR, General Comment No. 14: The Right to the Highest Attainable Standard of Health (Article 12 of the Covenant), 11 August 2000, UN Doc. E/C.12/2000/4, para. 12.
[27] CESCR, General Comment 14, para. 43(f).

and revise existing drug policy. Many of these measures are retrogressive and reform must ensure compliance with obligations under the Covenant.

In light of the issues presented above, we wish to make the following recommendations:

- Call for an immediate end to the extrajudicial killings of drug suspects and investigate violations effectively, promptly thoroughly and impartially and where appropriate, take action against those allegedly responsible in accordance with international law, empowering the national human rights commission to lead on local proceedings.
- Undertake a comprehensive review and reform of drug policy that is human rights based, informed by scientific evidence and explicitly incorporates a harm reduction approach with a view to harmonising efforts across the law enforcement and health ministries and an objective to strengthen the capacity of the national health care infrastructure
- Comprehensive drug law reform must include the decriminalisation of drug use and drug possession for personal use, as well as the decriminalisation for possession of safe injecting equipment
- Close all compulsory drug detention facilities and remove compulsory drug treatment from the criminal code
- Adopt comprehensive anti-discrimination legislation that firmly protects individuals vulnerable to discrimination based on health status, including people who use drugs
- Re-launch and scale up harm reduction pilot programmes including needle and syringe programmes
- Rapidly develop and expand community based drug dependence treatment options

Submission to the Committee on Economic, Social and Cultural Rights
SOUTH AFRICA

Umzimvubu Farmers Support Network[1]
The International Centre on Human Rights and Drug Policy (HRDP)[2]

1. The following joint submission has been prepared by the Umzimvubu Farmers Support Network and the International Centre on Human Rights and Drug Policy. Its main objective is to illustrate how current approaches to illicit drug control engage important questions related to South Africa's compliance with obligations contained within the International Covenant on Economic, Social and Cultural Rights. In specific, this submission will highlight two ways in which current drug policies impact the economic, social and cultural rights of traditional rural farming communities in the Eastern Cape region of the country: 1. The harmful health and development consequences of the **aerial fumigation** of traditional cannabis crops grown by these communities, and 2. The socio-economic consequences these communities face because of barriers to the emerging **licit, medicinal cannabis market** in South Africa.

I. General information: Economic, Social, and Cultural Rights and Drug Policy

2. South Africa has been considered one of the most unequal countries in the world. During apartheid, the Eastern Cape region had high numbers of 'homelands', regions reserved for black South Africans, which received little support in infrastructure and public services.[3] As a result of this legacy, between 2005 and 2015, this same region had the lowest reduction of poverty levels[4] and in 2016 it was found to have the highest multidimensional poverty headcount ratio at 12.7%, with those living in rural areas being the most affected.[5]

3. The Eastern Cape, and more specifically the Pondoland[6] district,[7] is internationally known for its large cannabis production.[8] Although this industry may seem lucrative, the reality is that the standard of life for these South African farmers has not improved.[9] Through personal testimony, the local farmers of the regions of Pondoland, report that their crops of maize, pumpkin, beans and spinach are for their personal consumption and the crops of cannabis are their only source of income. Moreover, as

[1] Umzimvubu Farmers Support Network <http://ufsn.org.za> accessed 30 June 2018.
[2] International Centre on Human Rights and Drug Policy, An Academic Partner of the Human Rights Centre <http://www.hr-dp.org/> accessed 30 June 2018.
[3] The World Bank, 'Overcoming Poverty and Inequality in South Africa: An Assessment of Drivers, Constraints and Opportunities' Report' (March 2018) xi, xxv.
[4] The World Bank, 'Overcoming Poverty and Inequality in South Africa: An Assessment of Drivers, Constraints and Opportunities' Report' (March 2018).
[5] The World Bank, 'Overcoming Poverty and Inequality in South Africa: An Assessment of Drivers, Constraints and Opportunities' Report' (March 2018) 31.
[6] Kepe, T., 'Cannabis Sativa and rural livelihoods in South Africa: Politics of Cultivation, Trade and Value in Pondoland' 20 (5) Development Southern Africa (2003) 608.
[7] Laniel, L., Cannabis in Lesotho: A Preliminary Survey (UNESCO, Management of Social Transformations - Discussion Paper No.34) 1998 <www.unesco.org/most/dslaniel.htm> accessed on 6 July 2018.
[8] Craig Paterson, 'Prohibition & Resistance: A Socio-Political Exploration of the Changing Dynamics of the Southern African Cannabis Trade, c. 1850 – the present', Thesis in History-Rhodes University, (December 2009) 3.
[9] See Paterson (n 8) 4.

agricultural markets are geographically distant accessing alternative economic activities is currently not a viable development pathway. Income earned through the cannabis trade allows these communities to afford what they cannot grow, such as clothing items, oil and books.[10] It has also been reported that income from cannabis crops assists with school fees.[11]

4. South Africa is party to all existing United Nations Conventions relating to drugs,[12] which bind the state to control identified psychoactive substances. Each state has flexibility in their compliance with the obligations as laid out in these Conventions; however, restrictive measures must be put into place.[13] South Africa has adopted restrictive measures through national legislation. In 2015, the state also ratified the International Covenant on Economic, Social and Cultural Rights (ICESCR),[14] creating tensions (and perhaps direct conflicts) between obligations related to drug control and those contained in the Covenant.

5. Importantly, the communities represented in this submission have been cultivating cannabis for traditional uses for generations. Representatives of the farming communities report cannabis has been an integral part of the community's cultural and socio-economic lives for "generations", unable to pinpoint a specific linear chronology. Cannabis was not always illegal in South Africa. The ethnographic evidence from the 18th and 19th centuries demonstrates the enduring tradition of cannabis.[15] Understanding this historical and ethnographic context of these communities, it is difficult to ignore the ways in which forced eradication of these crops may violate the right to culture.[16] The aim of the aerial spraying is the total eradication of the practice of cannabis cultivation altogether—which, to these communities, is a long-established traditional way of living.

6. In 1922, the Customs and Excise Duties Amendment Act prohibited the cultivation of cannabis, among other drugs.[17] In 1937, the Weeds Act [18] was passed, which was more directed towards criminalizing the occupier or owner of a property and/or land where cannabis plants could be grown. This was a way more far-reaching Act that gave the South African Police Service (SAPS) much power to eradicate any "habit-forming drugs" from the lands.[19] Then came the Drugs and Drug Trafficking Act 140 of 1992[20] which criminalized the possession of drugs, with the exception of medical use. In Pondoland, communities rely solely on the cultivation and trade in cannabis. It represents "an important cash crop in a deeply impoverished subsistence economy." For more than 60 years, South Africa has

[10] Umzimvubu Farmers Support Network 'The Story inside the Mpondoland hut' (29 April 2006) <**http://ufsn.org.za**> accessed 7 July 2018
[11] Kimon de Greef, "Battle to stop dagga spraying" <https://www.groundup.org.za/article/battle-stop-dagga-spraying/> accessed 7 July 2018.
[12] United Nations, Single Convention on Narcotic Drugs (1961), as amended by the 1972 Protocol amending the Single Convention on Narcotic Drugs; United Nations, Convention on Psychotropic Substances (1971); United Nations, Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances (1988).
[13] ibid
[14] Cite the ICESCR.
[15] See Paterson (n 6) 26.
[16] International Covenant on Economic, Social and Cultural Rights (adopted 16 December 1966, Entered into Force 3 January 1976) 993 UNTS 3 (ICESCR) art 15 (c) 2.
[17] See Paterson (n 6) 52.
[18] Weeds Act, No. 42 of 1937.
[19] See Paterson (n 6) 53-54.
[20] https://daggacouple.co.za/wp-content/uploads/1992/11/South-Africa_Drugs-and-Drug-Trafficking-Act-no-140-of-1992.pdf

conducted regular eradication programmes but failed to curb cultivation, "which remains sustained by high demand for [cannabis] and a lack of alternative options for the farmers who produce it, among other factors."[21]

7. One of the most relied upon (and harmful) drug control measures in Pondoland is aerial spraying because of its capacity for rapidly eliminating large areas of cannabis fields. For nearly three decades, the South African Police (SAPS) have poisoned the crops before harvest with the herbicide glyphosate under the formulation name Kilo Max.[22] In a 2007-2008 annual report, SAPS declared that '1 754 hectares of cannabis fields were sprayed during spraying operations', although no further details were provided.[23] In 2015, those operations caught the attention of the media, following the publication of the reports provided by the International Agency for Research on Cancer (IARC), a semi-autonomous part of the World Health Organization (WHO), stating the consequences of glyphosate spraying could be distressing, since it was found that the chemical could potentially be carcinogenic.[24] In addition, there a was recent ruling in the United States against the company Monsanto, corroborated the IARC's findings regarding the health consequences of glyphosate.[25] In South Africa, several activists groups have demanded the halt of the practice, but the government has not followed recommendations.[26]

8. Importantly, the farming communities in Pondoland cultivate cannabis in fields and plots in close proximity to their homes (in some cases, right outside of the door step). Fumigation activity therefore does not discriminate between crops and homesteads, with community representatives reporting spraying activity directly onto homes, livestock, water sources, and people, including young children.

9. In addition to the harmful human health consequences of aerial spraying, it is important to note that Pondoland (and the cannabis growing area) is part (or on the cusp) of a biodiversity hotspot 'Maputaland-Pondoland-Albany', which is the second richest floristic region in Africa, with more than 540 species of birds, nearly 200 mammal species, 73 types of fishes and 8 100 types of plants.[27] As per the Convention on Biodiversity, State parties have an obligation to "introduce appropriate procedures requiring environmental impact assessment of its proposed projects that are likely to have significant adverse effects on biological diversity."[28] Likewise, the right to health contained within the Covenant includes the collective right to a healthy environment. While the threat aerial fumigation presents to

[21] Kimon de Greef, 'Cash crops poisoned in Pondoland' <https://www.groundup.org.za/article/cash-crops-poisoned-pondoland/; > accessed 7 July 2018.
[22] Kimon de Greef, "Cash crops poisoned in Pondoland" <https://www.groundup.org.za/article/cash-crops-poisoned-pondoland/ > accessed 7 July 2018; Arysta LifeScience 'Kilo Max: Reg. No.: L8310 Act /Wet No. 36 of/van 1947'.
[23] SAPS '2007-2008 Annual Report, Programme 2: Visible Policing' 108.
[24] International Agency for Research on Cancer (IARC), 'IARC Monographs Volume 112: evaluation of five organophosphate insecticides and herbicides' (20 March 2015) <https://www.iarc.fr/en/media-centre/iarcnews/pdf/MonographVolume112.pdf> accessed 07 July 2018.
[25] Sam Levine and Patrick Greenfield, 'Monsanto ordered to pay $289m as jury rules weedkiller caused man's cancer' (*The Guardian,* 11 Aguguest 2010) <https://www.theguardian.com/business/2018/aug/10/monsanto-trial-cancer-dewayne-johnson-ruling> accessed 11 August 2018.
[26] Kimon de Greef, "Cash crops poisoned in Pondoland" <https://www.groundup.org.za/article/cash-crops-poisoned-pondoland/; > accessed 7 July 2018.
[27] https://web.archive.org/web/20100424011849/http://www.biodiversityhotspots.org:80/xp/hotspots/maputaland/Pages/biodiversity.aspx
[28] https://www.cbd.int/convention/articles/default.shtml?a=cbd-14

such a rich and biologically significant area is clear, the long-term consequences of this harmful practice is not yet fully understood.

10. The harmful and punitive (and ineffective) policy of aerial fumigation emerges from the backdrop of a rapidly changing socio-legal landscape with respect to cannabis. As South Africa's social and political relationship with cannabis evolves, there are significant development opportunities for these traditional communities who remain deeply connected to the plant. As an alternative to illicit cultivation of cannabis, the government could facilitate access to the licit and rapidly expanding medicinal cannabis market.

11. While South Africa recognizes the licit production of cannabis for medicinal purposes, the Medical Controls Council (MCC)[29] are incredibly burdensome for low resource and income farmers. Therefore, access to this alternative is currently unattainable without significant revisions to existing legislation. In addition, the Guidelines published by the MCC regarding the cultivation of cannabis were not shared with the traditional, indigenous communities of South Africa. Neither did the MCC request the contribution of the Traditional Medicine Systems of South Africa, although cannabis is an indigenous plant which has been grown by these communities before and after its current prohibition. Instead, the MCC copied the Dutch model, often verbatim, requiring a pharmaceutical set-up, expensive indoor facilities and regulations, not suitable to the South African context.

12. Indigenous cannabis grown by thousands of communities and people in the South of Umzimvubu (who are represented in this submission) has little value in the illicit market owing to its low Tetrahydrocannabinol (THC)—the main psychoactive constituent of cannabis. However, the plants produced by these communities for generations are pharmacologically considered ideal cannabis for medical purposes. As such, traditional farming communities could play a key role in the medical cannabis market in South Africa, with the requisite political will. For example, a community-based monitoring programme or small-scale community farmer licenses. In addition, intergovernmental initiatives and an independent panel of experts could empower cannabis producing communities and support them to meet the requirements. Such an inclusive regulatory system would create employment among the communities, would help to reduce the illicit production of cannabis, and safeguard the cultural, economic, and social rights of these communities.[30]

13. The farmers in the region of Pondoland have a right to self-determination and to "freely pursue their economic, social and cultural development."[31] They must also be allowed to generate their own means of subsistence, including with the use of their natural wealth and resources, and shall in no case be deprived of this right.[32] Domestically, the South African Constitution enshrines this principle

[29] Medical Controls Council (MCC) <http://www.mccza.com/> accessed 12 July 2018; http://www.mccza.com/documents/959cb9e1Test.pdf; http://www.mccza.com/documents/84a71af62.44_Cannabis_growth_Feb2017_v1_for_comment.pdf

[30] Ricky Stone, 'General Comment and Outright Objection to the Medicines Control Council ("MCC") Guidelines for the Cultivation of Cannabis for Medical and Research Purposes in South Africa' (Boqwana Burns Inc, 30 March 2017).

[31] International Covenant on Economic, Social and Cultural Rights (adopted 16 December 1966, Entered into Force 3 January 1976) 993 UNTS 3 (ICESCR) art 1.

[32] International Covenant on Economic, Social and Cultural Rights (adopted 16 December 1966, Entered into Force 3 January 1976) 993 UNTS 3 (ICESCR) art 1.2.

by recognizing "the right of self-determination of any community sharing a common cultural and language heritage, within a territorial entity in the Republic."[33]

II. Recommendations

14. These are the recommendations for South Africa to fully respect its obligations under the International Covenant on Economic, Social and Cultural Rights :

- Formal abolition of the aerial spraying eradication programme.
- The state should facilitate access to the licit market of medicinal cannabis for the farmers involved in cannabis growing.
- Adopting a human rights-based approach to address the illicit drug production by the farmers. For example, the government should provide alternative production activities and allow the farmers themselves to contribute to the development and design of those programmes. [34]
- As this submission seeks to represent the voices and demands of the community of cannabis farmers in Pondoland, it must be emphasized that development and pathways away from illicit activity require roads. Many of these farming communities do not have roads that connect them with basic social and economic activities including schools, healthcare, and licit, alternative markets. Children walk three hours in some villages to school. When a community member passes away in more remote areas, the community must carry the bodies out for registration. Committing to more robust highway infrastructure is a key request from these farming communities.

[33] Constitution of South Africa (1996), Chapter 14: General Provisions, para 235.
[34] Committee on Economic, Social and Cultural Rights 'Concluding observations on the sixth periodic report of Colombia' (19 October 2017) UN Doc E/C.12/COL/CO/6, para 54.