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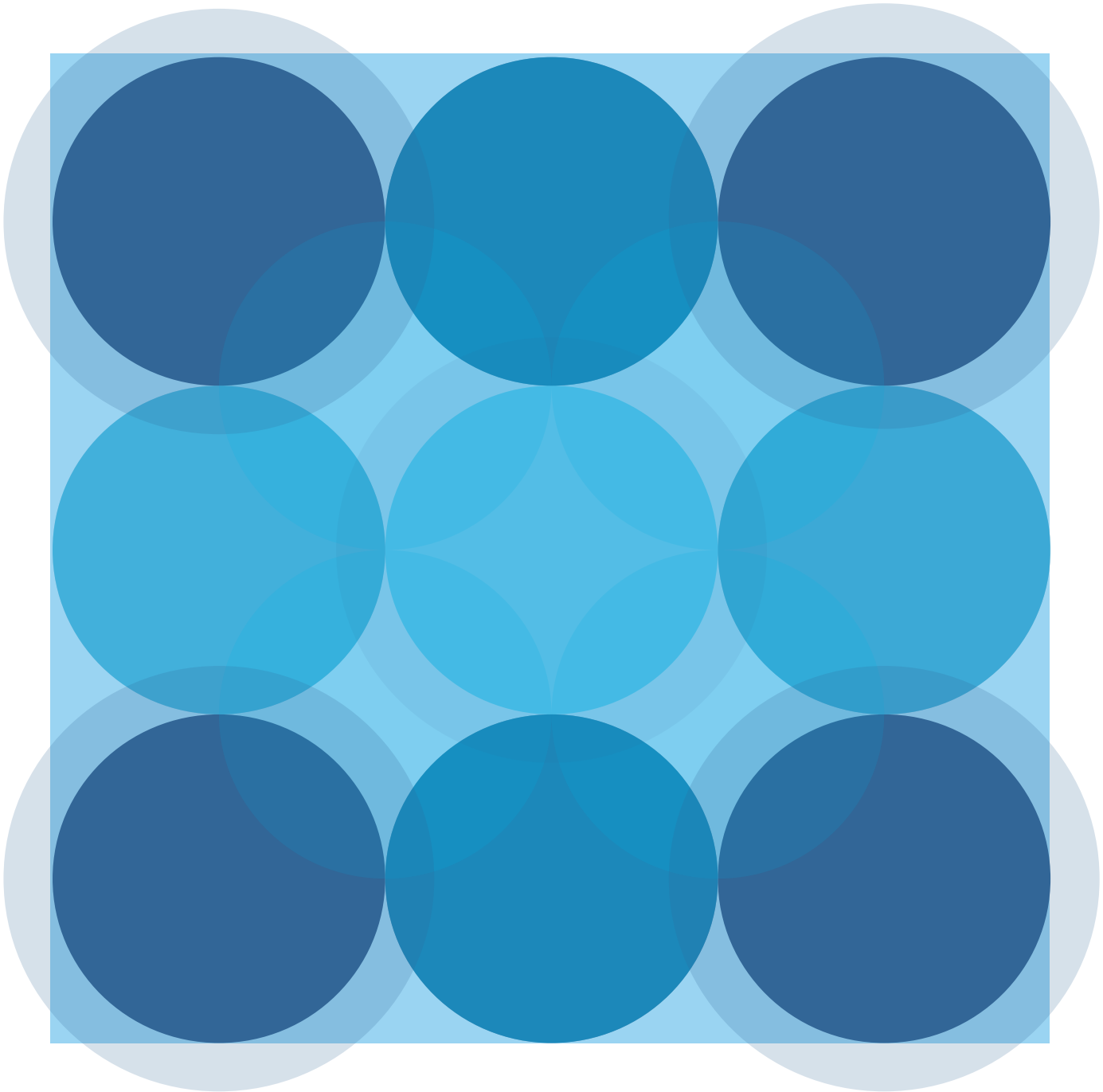
# TAKING STOCK OF HALF A DECADE OF DRUG POLICY

## AN EVALUATION OF UNGASS IMPLEMENTATION



# TAKING STOCK OF HALF A DECADE OF DRUG POLICY

## AN EVALUATION OF UNGASS IMPLEMENTATION

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# Foreword

The United Nations General Assembly Special Session (UNGASS) on drugs in 2016 and its Outcome Document did not imply a radical change in the international legal regime on controlled substances, such as cannabis, cocaine or heroin, as it maintained the prohibition of production, distribution and use of these substances, outside medical or scientific use, in spite of the well-documented negative consequences of this prohibition on democracy, human rights and public health. That was unfortunate as the world lost a real opportunity to eliminate one of the most substantial drivers of massive human rights violations all over the world in the last decades. However, the UNGASS was not an irrelevant moment either. It was a significant step in the right direction as the Outcome Document proposes important elements that allow, or even oblige, States to abandon the most extreme punitive interpretations of the international legal regime on controlled substances, that have created too much unnecessary suffering in the world.

The UNGASS Outcome Document rightly introduced a new language and narrative for dealing with drug policy, which goes beyond the classic three pillars of supply, demand and cooperation of previous UN documents on drug policy. The UNGASS Outcome Document stresses the need for States to adopt a public health and development-oriented approach to drug policy, which has to respect human rights, and adopt better metrics and indicators to evaluate the impacts and effectiveness of this policy. That general orientation of the Outcome Document is in itself very important. Besides, in certain aspects, the document goes further and makes more specific and important recommendations. For instance, instead of promoting punitive approaches in drug policies, the Outcome Document urges States to respect the principle of proportionality when establishing criminal drug offences and also to consider alternatives to criminal punishment and prison in this field. That is not a minor point if we take into account how, in many parts of the world such as in the United States or all over Latin America, the enormous increase in incarceration and the unjustified suffering it has caused in the most vulnerable populations has been strongly linked to extremely punitive versions of drug policy.

In that context, this very well documented IDPC report is timely as it evaluates, five years after the UNGASS, whether these progressive orientations

Rodrigo Uprimny

of the Outcome Document have been really taken onboard and implemented by governments and have had positive impacts on the evolution of drug policies. As the reader will see, the balance is mixed. On some aspects, important progress has been achieved. For instance, today we have been able to reduce the strong separation that previously existed between discussions on drug policy, usually led by the CND in Vienna, and discussions on human rights, usually led in Geneva. This sort of Berlin wall between Geneva and Vienna, so to speak, has fallen; it is more and more accepted that any discussion on drug policy has to take into account all the human rights obligations of States. Conversely, most human rights bodies have understood that drug policy is not a monopoly of the Commission on Narcotic Drugs (CND) or the International Narcotics Control Board (INCB) in Vienna and that they must monitor any human rights violations associated with drug policy. For example, several human rights treaty bodies, such as the Committee on Economic, Social and Cultural Rights, of which I am member, the Committee on the Rights of the Child or the Human Rights Committee, have increasingly made recommendations to States to adjust their drug policies to human rights standards, for instance recommending the adoption of harm reduction programmes.

However, as this report rightly stresses, these advances, no matter their importance, have not been able to counterbalance the lack of progress in other fields of drug policy: or even worst, the regressive steps taken by some countries towards more repressive approaches, including my own

country, Colombia, in which the government envisages to re-establish aerial spraying of coca fields with glyphosate, in spite of the recommendations against this measure made by many human rights bodies and most experts in drug policy.

I totally agree with the main conclusions of the report: the advances made since the UNGASS for a more humane and democratic drug policy are not only very limited; they also face risks of retrogression. However, this situation should not discourage all persons, organisations or States committed to drug policy reform. On the contrary, we need to maintain our efforts and enthusiasm for drug reform at the international and national level, making all efforts to ensure that at least all States take seriously the commitments they undertook by adopting the UNGASS Outcome Document. We need to continue our efforts to eliminate, or at least, reduce significantly, the harms and suffering caused by repressive drug policies. And for that purpose, the concrete recommendations made by this report are very pertinent as they combine nicely reasonableness and courage.

## Rodrigo Uprimny

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Almost a decade has passed since Colombia, Mexico and Guatemala called urgently for a UN General Assembly Special Session (UNGASS) on drug policy. At the General Assembly in 2012, they stated that 'revising the approach on drugs maintained so far by the international community can no longer be postponed' and urged the UN to 'exercise leadership' to review all the available options, 'including regulatory or market measures', towards a more effective approach to address the challenge of drugs. It was not surprising that this push came from Latin America as the region has borne witness to the unmitigated devastation of punitive and repressive drug policies – which have ultimately failed to eradicate, or even reduce, the illegal drug market.

Five years on, it is important to take stock of what has been achieved since the UNGASS in 2016, and to see if, indeed, the urgent call for a revised approach was realised.

**Ann Fordham**

In many respects, the 2016 UNGASS is now widely considered a high point for progressive drug policy at UN level, with the UNGASS Outcome Document heralding a shift in rhetoric towards human rights, health and development. The gains made in the Outcome Document (detailed so well by Rodrigo Uprimny, with whom I humbly share this foreword) were hard fought and hard won by several member states strongly committed to ensuring greater human rights accountability in drug policy. These difficult inter-governmental negotiations were accompanied and supported by civil society and, in hindsight, the UNGASS was a galvanising moment for the global drug policy reform movement. Working to leverage the opportunity this high-level moment provided, the movement became more diverse, visible, coordinated and vocal than ever before. The Civil Society Task Force worked tirelessly to ensure that the voices, stories and lived experiences of those most affected by drug policy were heard loud and clear in the UN debates. Working together with progressive member states, drug policy reform-oriented civil society managed to gain significant ground on health and human rights (including women's rights) in the Outcome Document.

While there have certainly been important gains over the last five years, and the momentum for reforms relating to cannabis (both for medical and for adult non-medical use) and broader decriminalisation continues to accelerate, there is still a huge chasm between the rhetoric and the reality on the ground as is chronicled in this timely report. Meaningful reforms have yet to materialise is most parts of the world and many governments remain

wedded to draconian measures with catastrophic impacts on communities. Civic space is under pressure at all levels as authoritarian governments seek to shut down dissident voices and undermine human rights defenders.

This year also marks 50 years since US President Nixon declared the 'war on drugs' – coining a phrase that has sadly become emblematic of so much needless human suffering in the futile pursuit of a 'drug-free society'. The world cannot suffer another 50 years of failed and damaging drug policies. Civil society must continue to lead the way, fighting to maintain civil space, speaking truth to power, lifting up the voices of the most affected and challenging harmful drug policies and approaches.

In addition to outlining progress, or lack thereof, this report also provides clear recommendations on how the global community can truly centre health, human rights and development into drug policy responses. Together with the seminal 2018 UN Common Position on drug-related matters, these recommendations set up a blueprint for drug policy reform for the next five years. However the option of 'regulatory' approaches was still considered a step too far and was cautiously avoided in both documents – although reforms on the ground continue regardless.

There is still hope that a decade after the 2016 UNGASS, the 'revised approach' called for at the very inception of this whole process will truly be underway, and that governments will have the courage to implement much needed and urgent reforms putting human rights, social justice, racial justice and gender equality at the centre of drug policies.

**Ann Fordham**
**IDPC Executive Director**

# Acronyms

| | |
|---|---|
| **AIDS** | Acquired Immune Deficiency Syndrome |
| **ARQ** | Annual Report Questionnaire |
| **ATS** | Amphetamine Type Stimulants |
| **CCDC** | Compulsory drug detention centre |
| **CCPCJ** | Commission on Crime Prevention and Criminal Justice |
| **CND** | Commission on Narcotic Drugs |
| **CSTF** | Civil Society Task Force |
| **DCR** | Drug consumption room |
| **ECDD** | Expert Committee on Drug Dependence |
| **EU** | European Union |
| **HIV** | Human Immunodeficiency Virus |
| **ICEERS** | International Center for Ethnobotanical Education, Research, and Service |
| **IDPC** | International Drug Policy Consortium |
| **INCB** | International Narcotics Control Board |
| **LGBTQ+** | Lesbian, Gay, Bisexual, Transgender and Queer and others |
| **NGO** | Non-Governmental Organisation |
| **NPS** | New Psychoactive Substances |
| **NSP** | Needle and Syringe Programme |
| **OAT** | Opioid Agonist Therapy |
| **OHCHR** | Office of the High Commissioner for Human Rights |
| **OST** | Opioid Substitution Therapy |
| **PNIS** | *Programa Nacional Integral de Sustitución de Cultivos Ilícitos* (National Comprehensive Program for the Substitution of Illicit Crops) |
| **SDGs** | Sustainable Development Goals |
| **SSDP** | Students for Sensible Drug Policy |
| **TNI** | Transnational Institute |
| **UK** | United Kingdom |
| **UN** | United Nations |
| **UNAIDS** | Joint United Nations Programme on HIV/AIDS |
| **UNDP** | United Nations Development Programme |
| **UNDRIP** | UN Declaration on the Rights of Indigenous Peoples |
| **UNGASS** | United Nations General Assembly Special Session |
| **UNICEF** | United Nations Children's Fund |
| **UNODC** | United Nations Office on Drugs and Crime |
| **USA** | United States of America |
| **WHO** | World Health Organization |

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# Executive Summary

April 2021 marks the five-year anniversary of the 2016 United Nations General Assembly Special Session (UNGASS) on drugs. This report aims to take stock of progress made on the implementation of the operational recommendations included in the UNGASS Outcome Document. Using desk-based research, and drawing on data and analysis from UN reports, academia, civil society and the community, the report focuses on six critical areas: public health, development, human rights, civil society engagement, UN agency collaboration and cooperation, and drug policy evaluation. While some progress has been undeniably made, the research gathered in this report shows that in the last five years the gap between policy commitments on paper and meaningful change on the ground has continued to widen.

## A public health approach

World Health Organization (WHO) data shows an increase in the number of people who died of 'drug use disorders' from 154,811 in 2015 to 181,758 in 2019, with the total number of deaths associated with drug use (including those related to HIV and hepatitis C) estimated at 585,000 in 2017. People who inject drugs remain particularly vulnerable to HIV, hepatitis C and tuberculosis infection, while overdose deaths have reached record highs. The continued lack of access to harm reduction and evidence-based treatment services is one of the main reasons for this trend, with little progress made since 2016. The ongoing criminalisation, stigmatisation and acts of intimidation, abuse, ill-treatment and torture against people who use drugs are also major contributing factors. Restrictions due to the COVID-19 pandemic have further limited availability and access – although in some contexts COVID-19 has led to the development of innovative harm reduction approaches, and to much-needed flexibility in the rules for accessing treatment.

Meanwhile, five billion people around the globe have little to no access to controlled medicines for pain relief, anaesthesia and the treatment of drug dependence, mainly due to unnecessary restrictive regulations. The problem predominantly affects the world's poorest, especially in the Global South. This is despite advances in global commitments to address this ongoing crisis. The long-overdue recognition of the medicinal value of cannabis by the UN in December 2020 is a small, but significant, step in the right direction.

## A development-oriented approach

There has been a welcome shift in the global discourse on development and drug policies since 2016, from an eradication-focused approach to a greater emphasis around sustainable development and livelihoods – linking drug policies to the Sustainable Development Goals (SDGs). Nevertheless, these new commitments have yet to materialise at country level. In most contexts, crop eradication campaigns have continued, destroying livelihoods and the environment, and fuelling human rights abuses, social unrest and violence, principally on the world's poorest farmers. In areas where alternative development programmes are in place, inadequate sequencing or implementation, lack of access to infrastructure and legal markets, and the expansion of extractive industries have often left farmers with no other choice than to continue cultivating illegal plants.

In urban areas, involvement in the supply side of the illegal drug market, such as selling or transporting drugs, is predominantly attributed to poverty, as well as racial, ethnic, class, and gender inequalities, all of which are exacerbated by punitive drug laws. There again, criminalisation and incarceration continue to be the dominant approach, thus undermining the sustainable urban development approach needed to address such inequalities.

## A human rights approach

Progress has been made in the recognition of the multiple human rights abuses committed in the name of drug control by UN human rights bodies, as well as at the UN in Vienna. However, the shift in rhetoric since the 2016 UNGASS has not led to meaningful change for communities on the ground.

Women continue to be disproportionately impacted by punitive drug control measures. Women who use drugs are particularly vulnerable to health harms, but their access to gender-sensitive harm reduction and treatment services has not improved over the past five years. Stigma, criminalisation, fear of loss of child custody and other punitive measures play a major role in deterring women from accessing the services that do exist. As was the case five years ago, the proportion of women incarcerated for drug offences remains high at 35% of women deprived of their liberty

globally. In illegal crop cultivation areas, women's lives are marked by various forms of discrimination, isolation and marginalisation – which are not adequately addressed in drug policy and alternative development programmes.

Children and young people remain a main target – and justification for – punitive drug control approaches. Health measures for young people often consist of 'just say no' prevention campaigns, forced urine testing and police searches at school, neglecting much-needed access to age-sensitive harm reduction services. Drug law enforcement measures have also resulted in a range of human rights violations on children and youth. The killing or incarceration of parents and caregivers in drug control operations have had devastating impacts on their children, including distress, traumatic separation, loss of income, difficulties at school and bullying. The imposition of a criminal record on a child leads to reduced prospects for access to higher education and employment.

Punitive drug control has also had a major impact on the criminal legal system, contributing to overcrowding through the ongoing use of pretrial detention, mandatory minimum and disproportionate sentencing, delays in court decisions, limited access to legal aid, and lack of access to meaningful alternatives to prison and punishment. As a result, one in five people in prison worldwide continue to be incarcerated for drug offences, 550,000 of whom for simple drug use – with devastating consequences on prison overload and conditions of detention, especially in the context of the COVID-19 pandemic. Drug law enforcement and criminal sanctions have disproportionately affected women and people belonging to racial and ethnic minorities. Although some measures have been undertaken to decriminalise drug use, ensure more proportionate sentencing and offer alternatives to incarceration, the impacts on overall levels of incarceration have been minimal.

In parallel, survivors of human rights violations committed in the name of drug control have had no access to effective remedy. This is despite the acts of torture and cruel, inhuman and degrading treatment or punishment against people involved in illegal drug activities and people who use drugs, including abuses in compulsory drug detention centres and private treatment facilities, the ongoing use of corporal punishment, and police brutality, among others. Finally, no meaningful change has occurred since the UNGASS to protect the rights of indigenous groups, in line with the UN Declaration on the Rights of Indigenous Peoples.

## Ensuring the meaningful participation of civil society, especially affected communities

Although civil society involvement in global decision making processes on drugs has improved in some respects since the UNGASS, civil society continues to be left out of most local, national and global policy making processes, especially those whose lives are most affected by drug policies. The COVID-19 pandemic and associated government restrictions have further restricted civil society space at all levels of governance. Nonetheless, civil society organisations have continued to mobilise, both to protect and claim their human rights, and to provide life-saving access to key services for people on the ground.

## Improving UN agency collaboration and coordination

Some undeniable progress has been made to improve UN system-wide coherence on drug policy issues, including with the launch of the International Guidelines on Human Rights and Drug Policy and the adoption by all UN agencies of the UN System Common Position on drug-related matters. The regular engagement of UN human rights, health and development agencies in Vienna-based debates – and increased visibility of drug policy issues in their overall work – have also been a positive development since 2016. Nevertheless, much remains to be done, in particular with regards to the dissemination and operationalisation of the Common Position by its implementation Task Team.

## Evaluating drug policy success

Since the UNGASS, efforts have been made to improve the way the UN collects data on drug policy. A revised Annual Reports Questionnaire (ARQ) was adopted in 2020, which provides an improved tool to measure drug policy success, notably in terms of access to health services and use of alternatives to incarceration, with gender-disaggregated data. Nonetheless, the tool does not go far enough in truly assessing the human rights and development impacts of drug policies and remains overly focused on assessing the overall scale of the illegal drug market. Although the Task Team in charge of implementing the UN System Common Position could play a critical role in collecting much-needed drug-related data from other parts of the UN, its role in this domain has yet to materialise. The current UN data collection mechanism on drugs also fails to recognise the critical role played by civil society in this area, despite efforts made by various NGOs to fill the gap in data collection, monitoring and evaluation.

## Recommendations for the next decade of drug policy

- Ensure the meaningful participation of civil society, in particular affected communities, in local, national, regional and international drug policy making, implementation, monitoring and evaluation, and actively promote civil society space via institutionalised channels for participation, political and financial support.
- Ensure the wide dissemination and operationalisation of the UN System Common Position and a stronger, adequately funded, role for its implementation Task Team, including in data collection.
- Improve access to, and sustainable funding for, harm reduction, treatment and controlled medicines, with specific emphasis on women, LGBTQ+ communities, youth, ethnic minorities and people deprived of their liberty – including amidst the COVID-19 pandemic. Ensure that all health interventions are strictly voluntary, based on scientific evidence, and respectful of the rights and dignity of those wishing to access them.
- Adopt development-oriented drug policies that truly address the poverty, marginalisation, lack of access to land and basic services, in both rural and urban areas, including for women, ethnic and racial minorities and indigenous groups.
- Review drug laws and policies to remove all punishments for drug use and possession for personal use, ensure proportionate penalties and sentencing practices, use meaningful alternatives to incarceration and punishment and ensure access to legal aid – with the goal of using prison only as a means of last resort.
- Abolish the death penalty in all circumstances, and ensure that penalties for those currently on death row are commuted to a sentence commensurate with the severity of the offence.
- Ensure timely access to justice and reparations for survivors of human rights violations committed in the name of drug control, such as extrajudicial executions, police brutality, and abuses committed in public and private drug treatment centres.
- Reduce the prominence of indicators focusing on the overall scale of and flows within the illegal drug market, and focus instead on more meaningful indicators to measure progress towards protecting health, improving human rights, welfare, gender equality, and reducing levels of violence.

# Notes

# Part 1
## Introduction

19 April 2021 marks the five-year anniversary of the adoption of the Outcome Document of the United Nations General Assembly Special Session (UNGASS) on drugs.[5] Calls to hold a Special Session on drug-related issues had originated from one of the regions most affected by repressive drug policies and their consequences on security, development, health and human rights issues: Latin America, following a joint declaration from the Presidents of Colombia, Guatemala and Mexico.[6] The UNGASS took place at a time of unprecedented calls for drug policy change at global and national level. In addition, the fact that the Special Session was held soon after the adoption of the 2030 Agenda for Sustainable Development influenced the overall shift in narrative and encouraged member states to adopt a broader development perspective on drug control.

Soon after the UNGASS, reform-minded NGOs and policy makers alike recognised the major steps forward made at the Special Session, as well as within its Outcome Document, in particular in the promotion of drug policies better aligned with the promotion of health, human rights and development. The Special Session was a catalyst moment to promote more coherence within the UN system in the area of drug policy, as an unprecedented number of UN agencies engaged in the debates.[7] Another welcome aspect of the UNGASS was the broad acknowledgement that civil society has a central role to play in the design and implementation of drug policies at global level.[8]

Yet, in the immediate aftermath of the UNGASS, many drug policy reform advocates had a feeling of disappointment over the final iteration of the document, which had taken over two years for member states to negotiate. Among other concerns, the Outcome Document reiterated the key objective for the international community to promote a 'society free of drug abuse'. This objective, included in some form in all UN high-level political documents on drugs, has not only been unrealistic (in 2020, the United Nations Office on Drugs and Crime (UNODC) concluded that 'Drug use around the world has been on the rise'[9]), but also harmful as it has justified widespread human rights abuses committed in the name of drug control. Furthermore, critical issues failed to be incorporated in the Outcome Document, including the need to abolish the death penalty, the differentiated impacts of drug control on LGBTQ+ communities, the exploration of legal regulation models for certain drugs, or the unequivocal support for a harm reduction approach.[10]

Nonetheless, the UNGASS Outcome Document constitutes a milestone in global drug policy. Since then, various member states have pushed back against the Outcome Document, seeking to downplay it by promoting instead the 2009 Political Declaration. This was made particularly clear during the 2019 Ministerial Segment and the negotiation of its Ministerial Declaration,[11] which refers to all global commitments adopted since 2009. [12] In this context, it is critical that the Outcome Document remains prominent in international drug policy debates.

Paragraph 9 of the UNGASS Outcome Document resolves to:

> 'take the steps necessary to implement the above-listed operational recommendations, *in close partnership with the United Nations and other intergovernmental organizations and civil society*, and to share with the Commission on Narcotic Drugs, as the policymaking body of the United Nations with prime responsibility for drug control matters, *timely information on progress made in the implementation of these recommendations*' (emphasis added).

Half a decade after the adoption of the Outcome Document, it is therefore time to take stock of 'progress made' since April 2016 on the implementation of the document's many recommendations. In February 2017, in an effort to reflect on the progressive aspects of the UNGASS Outcome Document, IDPC produced an analysis of the most useful elements of the Outcome Document that civil society could use for drug policy advocacy in the years to come, in the briefing paper 'How

to capitalise on progress made in the UNGASS Outcome Document: A guide for advocacy'. The briefing focused on four overarching issues: public health, development, human rights and civil society engagement.[13]

Building upon our 2017 briefing paper, this report aims to analyse what progress has been made to date in the implementation of the recommendations included the UNGASS Outcome Document in these four critical areas – as well as on two additional themes: the improvement of UN agency collaboration and cooperation, and the consideration of how to evaluate success in drug policy.

This analysis is all the more urgent as drug policy discussions have shifted significantly over the past five years, in particular on issues associated with human rights and gender, and as health priorities have shifted drastically to respond to the COVID-19 pandemic. The report is based on desk-based research using data from UN reports, academia, as well as civil society and community research. It also seeks to give a voice to the many communities that are most affected by drug policies around the world, via quotes and testimonies that truly reflect the impacts of current drug policies on the ground – beyond data and numbers.

# Notes

# Part 2

## A public health approach

# 2.1 Harm reduction

**Relevant UNGASS recommendations:**

- Paragraph 1.m 'Promote (…) the use of opioid receptor antagonists such as naloxone to reduce drug-related mortality'.
- Paragraph 1.o. 'Consider (…) effective measures aimed at minimizing the adverse public health and social consequences of drug abuse, including appropriate medication-assisted therapy programmes, injecting equipment programmes, as well as antiretroviral therapy and other relevant interventions that prevent the transmission of HIV, viral hepatitis and other blood-borne diseases associated with drug use, as well as consider ensuring access to such interventions, including in treatment and outreach services, prisons and other custodial settings (…)'.

## Drug-related harm and deaths

In 2016, UN member states committed to 'promoting the health, welfare and well-being of all individuals, families, communities and society as a whole' (paragraph 1). Three years later, the international community took stock of progress made over the past decade in international drug policy at the 2019 Ministerial Segment held in Vienna. Two of the 'persistent and emerging challenges' identified in the resulting Ministerial Declaration were that 'the rate of transmission of HIV, the hepatitis C virus and other blood-borne diseases associated with drug use, including injecting drug use in some countries, remains high', and that 'the adverse health consequences of and risks associated with new psychoactive substances have reached alarming levels'.[14]

Indeed, a World Health Organization (WHO) comparison of the number of people who died as a result of 'drug use disorders' between 2015 and 2019 showed that this number increased from 154,811[15] to 181,758.[16] Quoting data from the Global Burden of Disease, the 2020 World Drug Report estimates the total number of deaths associated with drug use (including those associated with HIV and hepatitis C) at 585,000 (2017 data).[17] Half of those deaths were 'attributed to liver cancer, cirrhosis and other chronic liver diseases related to hepatitis C'.[18]

The UNODC, WHO, Joint United Nations Programme on HIV and AIDS (UNAIDS) and World Bank estimated the prevalence of hepatitis C among people who inject drugs worldwide to be 48% in 2018, representing 5.5 million people aged 15-64.[19] A 2019 study published in The Lancet also found that 39% of new hepatitis C infections are estimated to be among people who inject drugs.[20]

People who inject drugs represented 10% of all new HIV infections in 2019,[21] a 2% increase from 2016 data,[22] and representing 1.4 million people.[23] This number rises dramatically in certain regions, especially in Eastern Europe and Central Asia and the Middle East and North Africa, where 48% and 43% of all new HIV infections respectively are associated with injecting drug use. In 2019, UNAIDS estimated that a person who injects drugs is 29 times more likely to acquire HIV than a person who does not.[24]

According to the WHO, people who use drugs 'are at increased risk of [tuberculosis], regardless of HIV status'.[25] People living with HIV who inject drugs are two to six times more likely to develop tuberculosis, and tuberculosis is the leading cause of mortality among people who inject drugs and who are living with HIV.[26]

People who use drugs in prison are particularly vulnerable to health-related harms. According to UNAIDS, 'recent incarceration is associated with an 81% and 62% increased likelihood of HIV infection and hepatitis C infection, respectively' among people who inject drugs.[27] Similarly, the risk of contracting tuberculosis in prison is 23 to 50 times that of the general population, with the stigmatisation and criminalisation of people who use drugs contributing to higher rates of tuberculosis.[28]

According to the 2020 World Drug Report, the number of drug overdose deaths remains at record high levels.[29] The USA reported a total of 67,367 drug overdose deaths in 2018 (latest available data)[30]

# FIVE YEARS AFTER UNGASS | HEALTH

## 'Drug-related' deaths

**A life lost every 54 seconds**

**585,000**
deaths related to drug use in 2017

## Drug dependence and treatment

**↗21%**
People living with drug dependence

29.5 million (2014) > 35.6 million (2018)

**Only 1 in 8 engaged in treatment**

**↘26%**
between 2014 - 2018

## Harm reduction (# of countries)

**OAT** opioid agonist therapy

| (community) | (prisons) |
|---|---|
| 79 > 84 | 53 > 59 |

**NSP** needle & syringe programmes

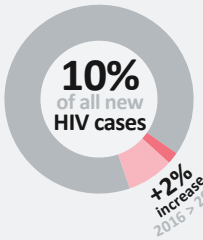
| (community) | (prisons) |
|---|---|
| 91 > 86 | 8 > 10 |

**Naloxone** (peer-led distribution) 16

**DCRs** 13
drug consumption rooms

Legend
#: 2016
#: 2020

## People who inject drugs




**29x** more likely to acquire HIV than people who don't inject drugs

**2 in 5** new Hepatitis C cases

**Imprisonment: A health hazard**
Incarceration is linked to an increased likelihood of acquiring:

HIV ↗81% | HCV ↗62%

People living with HIV who inject drugs are more likely to develop **2-6x** tuberculosis

## Access to controlled medicines

**5,000,000,000**

Approximately 5 billion people live with little to no access to controlled medicines

- Ex. morphine, fentanyl — Pain relief
- Ex. ketamine — Anaesthesia
- Ex. methadone — Drug dependence treatment

- Restrictive policies
- Insufficient knowledge
- Stigma
- High costs

## Medical cannabis

Australia, Austria, Belgium, Canada, Colombia, Croatia, Czechia, Ecuador, El Salvador, France, Germany, India, Italy, Jamaica, Mexico, Morocco, Nepal, Netherlands, Poland, South Africa, Spain, Sweden, Switzerland, Thailand, United Kingdom, United States, Uruguay

**27** | **25**

**CND Member States** voted on the WHO's recommendation to remove cannabis from Schedule IV of the 1961 Convention.

(Plus one abstention: Ukraine).

Afghanistan, Algeria, Angola, Bahrain, Brazil, Burkina Faso, Chile, China, Côte d'Ivoire, Cuba, Egypt, Hungary, Iraq, Japan, Kazakhstan, Kenya, Kyrgyzstan, Libya, Nigeria, Pakistan, Peru, Russia, Togo, Turkey, Turkmenistan


compared to 63,632 in 2016[31] – bringing the total number of deaths to 201,236 between 2016 and 2018 alone. In Canada, a worrying 17,602 opioid overdose deaths were recorded between January 2016 and June 2020, with 1,628 occurring between April and June 2020 – representing the highest quarterly count since national surveillance began in 2016, and a 54% increase from the same time period in 2019.[32]

## Access to harm reduction services

The continued lack of access to harm reduction services worldwide is one of the main reasons for this situation.[33] A major point of contention during the negotiation of the Outcome Document was, in fact, the inclusion of wording on harm reduction, a concept that remains contested by various member states. After months of protracted discussions behind closed doors, member states once again avoided the words 'harm reduction' and instead focused on specific interventions, in particular those included in the 'WHO, UNODC, UNAIDS Technical Guide for countries to set targets for universal access to HIV prevention, treatment and care for injecting drug users', with an explicit mention, for the first time, of 'injecting equipment programmes' and 'medication-assisted therapy programmes' in the community and in prisons (paragraph 1.o), and 'naloxone' distribution 'for the prevention and treatment of drug overdose' (paragraph 1.m).

> **"The harm reduction program in Kenyan has expanded from the initial 60 in 2014 to over 7000 in 2021. Several other partners have come in to support women who use drugs, we have been trained, we have been counselled, and we feel like community leaders. At this point we are able to provide leadership to our peers, something that we could never do without therapy."**
>
> **A woman who uses drugs in Kenya shares her experience on how accessing harm reduction services has improved her quality of life[34]**

A comparison of data from 2016 and 2020 shows that limited progress has been made on the availability and coverage of these services. With regards to access to needle and syringe programmes (NSP) and opioid agonist therapy (OAT), very little change occurred, despite some progress in Sub-Saharan Africa. According to the Global State of Harm Reduction,[35] of the 158 countries and territories that reported injecting drug use, 91 implemented NSPs in 2016, and 79 countries had at least one OAT in place. The same report's 2020 data reported 86 countries implementing NSPs (five less than in 2016) and 84 countries with OAT (five more than in 2016).[36]

In 2020, UNAIDS raised concerns over the fact that, in countries where harm reduction is available, services are provided 'mostly on a very small scale, and often in legal contexts that criminalize drug use and discourage people from accessing services'.[37] For instance, regarding NSPs, only nine out of 63 countries (where data was available) distributed a sufficient amount of needles and syringes to people who inject drugs (estimated at above 200 needles and syringes per person who injects drugs per year[38]) between 2015 and 2019 (see Figure 1).

With regards to harm reduction in prisons, there was a slight increase in availability globally, with 10 countries implementing NSPs in at least one closed setting in 2020 compared to eight in 2016, while the number of countries offering OAT in prison increased from 53 countries in 2016 to 59 countries in 2020 – although it should be noted that many of these programmes are pilot projects with low coverage.[39, 40,] Since 2020, Kenya opened its first OAT in the Shimo La Tewa Prison in Mombasa, providing treatment to 80 women and 125 men (as of February 2021).[41]

Another area of concern is the continued lack of availability of peer-led naloxone distribution. In many cases, overdoses are witnessed by a family member, a peer or someone whose work brings them into contact with people who use opioids;[42] peer-led naloxone distribution is therefore a critical harm reduction intervention, as increased access to naloxone for people likely to witness an overdose can significantly reduce the numbers of opioid overdose deaths. However, in 2020 peer-led naloxone distribution was only available in 16 countries,[43] while important but limited steps forward were made to improve access (such as including naloxone in national lists of essential medicines, relaxing rules on take-home naloxone, etc.).[44]

Beyond these harm reduction interventions, in our 2017 report 'How to capitalise on progress made in the UNGASS Outcome Document', IDPC suggested

**Figure 1.** Coverage of needle and syringe programmes in countries with available data, 2015-2019*


** Coverage is considered high if the number of needles and syringes distributed per person who injects drugs per year is above 200, medium if it is between 100 and 200, and low if it is below 100.*

*Taken from:* UNAIDS (2020), *Seizing the moment: Tackling entrenched inequalities to end epidemics – Global AIDS update*

that the Outcome Document's recommendations could be interpreted more widely to encompass additional harm reduction services, such as drug checking[45] and drug consumption rooms (DCR).[46] It should be noted here that the International Narcotics Control Board (INCB) has recognised the efficacy of DCRs to reduce the harms associated with injecting drug use, citing research concluding that such services have succeeded in attracting hard-to-reach populations, promoting safer injection practices, reducing the risk of overdose, and decreasing public drug injections, discarded syringes, and other drug-related litter in the community.[47] In 2016, nine countries around the world operated a total of 90 DCRs, most of which located in Western Europe[48] with only two based in Vancouver, Canada and Sydney, Australia.[49] This is an area where progress has been made over the past five years, with four more countries (Belgium, Luxembourg, Mexico and Portugal) now opening DCRs, and over 40 such facilities opening in Canada in an effort to curb overdose deaths.[50]

As for drug checking services, these are available in nine European countries (Austria, France, Italy, Luxembourg, the Netherlands, Portugal, Spain, Switzerland and the UK), Australia and New Zealand and the USA, and are increasingly available (although in limited scope) in Latin America, including in Brazil,[51] Chile,[52] Colombia,[53] Mexico[54] and Uruguay.[55] However, these services remain non-existent in Africa and South and Southeast Asia[56] and, in many contexts, these services have been halted or reduced amidst the COVID-19 pandemic.

Yet another issue is the lack of harm reduction response for people who use stimulants – despite the fact that amphetamine-type stimulants (ATS) are the second most commonly used drugs globally after cannabis.[57] For instance, NSP provision remains limited for people who use stimulants. In Western Europe, lack of access to sterile needles and syringes has been associated with local HIV outbreaks in various countries in the past five years.[58] In addition, while stimulants can be injected in DCRs, many of these facilities do not allow smoking or inhaling,[59] while sterile smoking equipment is rarely distributed. Nonetheless, safer smoking kits for crack cocaine, cocaine paste and ATS are distributed in various countries and jurisdictions (e.g. in Portugal and Puerto Rico), while harm reduction programmes are in place in various Latin American countries for people who use cocaine and its derivatives. In Asia, various pilot programmes focus on outreach and distribution of safer smoking kits, plastic straws, harm reduction information and access to testing and treatment for HIV, hepatitis C and tuberculosis.[60]

Data suggests that the availability of harm reduction services for people who inject drugs worsened during the COVID-19 pandemic. A UNAIDS study of 80 countries showed that HIV service provision for people who inject drugs improved in only one country, and deteriorated in 23 countries.[61] These disruptions have included interruptions in NSPs, more restricted access to OAT and shelters, breaches of confidentiality for OAT patients (for instance when clients must reveal to the police that they are receiving OAT to be able to travel to the clinic or hospital), etc. The pandemic has also severely hit homeless people who use drugs who are unable to abide by isolation rules.[62] UNAIDS also found that the measures taken to address the pandemic had made people who use drugs 'more vulnerable to violence and service disruption, as they cannot rely on consent and support from family to access services, cannot access support and health services due to lockdown restrictions, and face increased violence due to prolonged confinement in homes that may not be safe'.[63]

**Figure 2.** Changes in access to harm reduction services between 2016 and 2020[64, 65]

| | | |
|---|---|---|
| Progress made in OAT availability in the community between 2016 and 2020 | Increase from 79 to 84 countries | Now also available in Argentina, Burkina Faso, Côte d'Ivoire,[66] Palestine and Zanzibar |
| Progress made in OAT availability in prison between 2016 and 2020 | Increase from 53 to 59 countries | No longer available in Macau, Puerto Rico, Tunisia and Turkey.<br>Now also available in Afghanistan, Cyprus, Hungary, Iceland, Jordan, Kenya, Palestine, Seychelles, Tajikistan and Ukraine |
| Progress made in NSP availability in the community between 2016 and 2020 | Reduction from 91 to 86 countries | No longer available in Argentina, Brazil, Bulgaria, Jordan, Lao PDR, Mongolia, Palestine, Paraguay, the Philippines, Turkmenistan, Uruguay and Zanzibar.<br>Now also available in Algeria, Benin, Iceland, Mali, Mozambique, Nigeria and Sierra Leone |
| Progress made in NSP availability in prison between 2016 and 2020 | Increase from 8 to 10 countries | Now available in Canada and North Macedonia, as well as Armenia, Germany, Kyrgyzstan, Luxembourg, Moldova, Spain, Switzerland and Tajikistan |
| Availability of peer-led naloxone distribution in 2020* | Available in 16 countries | Available in Afghanistan, Australia, Canada, Denmark, Estonia, India, Italy, Mexico, Myanmar, New Zealand, Norway, Puerto Rico, the UK, Ukraine, the USA and Vietnam |
| Availability of drug consumption rooms in 2020* | Available in 13 countries | Available in Australia, Belgium, Canada, Denmark, France, Germany, Luxembourg, Mexico, Netherlands, Norway, Portugal, Spain and Switzerland |

** No comparable data available for 2016*

> **"I cannot really understand why the police are behaving like they want to make our life even more difficult than it already is. Being aggressive towards the vulnerable only creates more vulnerability… It is ridiculous man, I am homeless, where I am supposed to go?"**
>
> **Babis, a homeless person who uses drugs. He was fined €600 in Athens for staying outside despite the lockdown[67]**

Beyond the COVID-19 pandemic, several other factors explain the lack of progress made in addressing drug-related risks and harm and in ensuring wider availability of harm reduction services for people who use drugs. These include the fact that 'Repressive enforcement of drugs laws, including harsh criminal penalties and the registration of convicted drug users, force people who use drugs away from public health services into hidden environments, increasing their risk-taking behaviours and heightening the chance of acquiring or transmitting HIV'.[68] Additional obstacles include lack of political will to push for a harm reduction approach (including from senior leadership within the UNODC itself)[69] and the continued funding crisis for harm reduction services – of the 31 countries that reported expenditure data to UNAIDS between 2014 and 2018, 71% of spending on HIV services for people who inject drugs was covered by international donors, rather than national budgets.[70] This is despite the pledge made by the international community in 2017 to 'strive to ensure that such funding contributes to addressing the growing HIV/AIDS epidemic among people who inject drugs, and HIV/AIDS in prison settings'.[71]

## 2.2 Drug dependence treatment

**Relevant UNGASS recommendations:**

- Paragraph 1.j. 'Encourage the voluntary participation of individuals with drug use disorders in treatment programmes, with informed consent'.
- Paragraph 1.k. 'Ensure non-discriminatory access to a broad range of interventions, including psychosocial, behavioural and medication-assisted treatmen'.t
- Paragraph 1.p. 'Promote and implement the standards on the treatment of drug use disorders developed by the United Nations Office on Drugs and Crime and the World Health Organization and other relevant international standards'.
- Paragraph 4.c. 'Promote effective supervision of drug treatment and rehabilitation facilities by competent domestic authorities to ensure adequate quality of drug treatment and rehabilitation services and to prevent any possible acts of cruel, inhuman or degrading treatment or punishment'

Recognising that drug dependence must be approached through health and social policy rather than through criminal law or morals (paragraph 1.i), the UNGASS Outcome Document sets an ambitious agenda for treatment. Amongst other goals, it encourages states to establish treatment systems that are evidence-based (paragraph 1.i), delivered on a voluntary basis (paragraph 1.j), offering a broad range of interventions (paragraph 1.k) that reflect the complex social causes and consequences of dependence (paragraph 1.i), and following international standards (paragraph 1.p). Member states are also 'invited (…) to consider' 'medically assisted treatment' (paragraph 1.o).

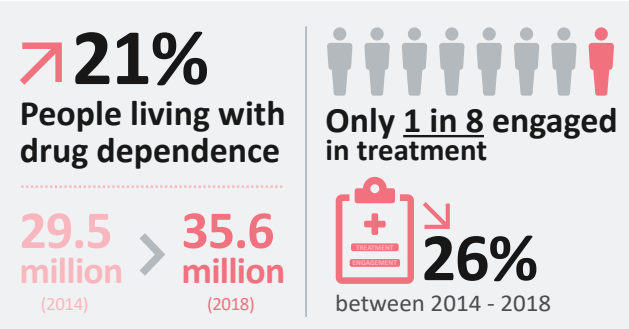
Crucially, the Outcome Document does not make the mistake of equating drug use with drug dependence, or with other challenges that can arise in connection to drug use. Neither does it assume that treatment should be aimed at ending or reducing drug use, though that might be the case when chosen by, and appropriate for, the person that seeks treatment. Just as drug use, dependence exists in a 'nuanced spectrum', and some people successfully integrate it into their life.[72] Health harms are mediated by social dynamics of criminalisation, marginalisation and oppression. In this complex environment, the goal of treatment should be to enable individuals to enhance autonomy and to achieve a state of physical and mental well-being, in their own terms.[73]

While progress has been made in certain settings, from a global perspective this agenda remains largely unfulfilled. The worldwide availability of drug dependence treatment remains at most at the same level it was five years ago, if not lower, while the take-up of OAT has stagnated. People who use drugs also continue to be subject to a range of human rights violations in treatment centres that do not rely on voluntary care or apply evidence-based methods, while public authorities remain inactive, or at times supportive of such centres.

> **"They bound my arms [and] my legs to a tree and they tied me. I tried to get them to let me out because it hurt…I'm not a bad person. I just need help with my addiction. But they didn't listen."**
>
> **Rosma Karlina, Women's Program Coordinator, AKSI Keadilan Indonesia (Action for Justice Indonesia).**[74]

### The global stagnation of treatment: Scarcity and lack of diversity

Despite the commitments set in the UNGASS Outcome Document, in the past five years there has not been a significant increase in the availability of treatment worldwide. A review of data from the World Drug Report shows that the estimated number of people with a drug dependence rose from 31 to 35 million since 2016, while the rate of those in treatment decreased from one in six to one in eight.[75] Even if we consider that this variation can be partly




due to the methodologies used to obtain these global estimates, it is fair to conclude that there has been no significant increase in the availability of treatment.

Furthermore, in many countries – particularly, but not only, in the Global South – the quality of drug dependence treatment provided is grossly inadequate,[76] not based on available scientific evidence, and treatment programmes are associated with serious human rights abuses (see below). Women have substantially less access to drug treatment than men, and where treatment exists, it rarely takes into account the specific needs and circumstances of women, such as the need to ensure that it is compatible with caretaking responsibilities.[77] Encouraged by the UNGASS Outcome Document, a number of inter-governmental organisations, including the African Union, the European Union (EU), and the Organization of American States,[78] have published standards or best practices on treatment; unfortunately, so far, the uptake has been limited. It is therefore critical that inter-governmental organisations and member states operationalise their commitment to promote international standards, including the 2020 WHO/UNODC 'International standards for the treatment of drug use disorders'.[79]

An effective treatment system should offer a broad range of options, from OAT to behavioural therapies, psychosocial support and abstinence-oriented approaches, so that people seeking treatment can choose the method(s) most appropriate to their personal circumstances and needs.[80] In the UNGASS Outcome Document, member states committed to 'ensure non-discriminatory access to a broad range of interventions, including psychosocial, behavioural, and medication assisted treatment' (paragraph 1.k). However, in the past five years the efforts made to diversify the treatments offered to people dependent on drugs have largely stalled, as best illustrated by the case of OAT.

A 'large evidence base'[81] shows that OAT[82] is highly effective for the treatment of opioid dependence, as well as in reducing overdoses and blood-borne infections, while increasing retention in the treatment of comorbidities such as Tuberculosis, HIV and hepatitis C, as well as having other social and cost benefits.[83] Despite this, since 2016, and as highlighted above, the number of countries providing OAT in the community has increased very slowly, while four countries have discontinued the service. While Europe is the region where OAT is most available, coverage is estimated to be at 50% in the whole continent, with countries such as Romania and Latvia offering coverage under 10%.[84] Even though methadone and buprenorphine are included the WHO Model List of Essential Medicines,[85] and OAT is recommended for the treatment of opioid dependence and for preventing ongoing transmission of blood-borne diseases such as HIV and hepatitis C (and supported by the WHO, UNAIDS, and UNODC), various countries (see more information below) have banned its provision, even when administered by civil society.

> **"Although I could not quit drug use, I could live a normal life with the help of methadone. But this has now been disrupted. My dosage was reduced against my will. Shouldn't the doctor and patient make common decisions in a therapy? Do I have no word in my own treatment?"**
>
> **Robi, from an OAT programme in Hungary where doses were arbitrarily reduced by the new administration during the COVID-19 pandemic. He lost his job because they required him to visit the OAT centre daily.**[86]

In other countries and jurisdictions, the range of options available to people seeking drug dependence treatment has also been restricted through the prioritisation of abstinence-based approaches, as illustrated by the cases of Hungary,[87] Brazil[88] or the Canadian state of Alberta,[89] amongst many others. Reduced funding for evidence-based drug dependence treatment programmes has further restricted access for those in need[90] while the focus on abstinence has resulted in a situation where those benefiting from diversion schemes are only offered abstinence-based treatment programmes that may not be adapted to their specific needs. In the USA, many drug courts and other institutions have promoted abstinence-only models for decades, and have denied access to OAT for people under their jurisdiction.[91]

In certain countries in the Eastern Europe and Central Asia region,[92] registration as a person who uses drugs is either required or common practice in order to access treatment. In addition to being an infringement on the right to privacy,[93] in a context where stigma and discrimination are widespread,

being included in these official registries can have very serious, material consequences, such as diminishing opportunities to accessing a job, or the deprivation of parental rights, particularly for women.[94]

## Limited room for innovation

Over the years immediately following the 2016 UNGASS, states have implemented existing innovations on agonist therapies at a very slow pace. For instance, while evidence has continued to emerge that heroin-assisted therapy is effective, outperforms methadone and buprenorphine-based therapies amongst certain groups (in particular people having used heroin for a long time and who did not respond well to more traditional OAT), and can be delivered safely,[95] the number of countries in which such programmes exist remains very small. Since 2016 heroin-assisted therapy only became available in one new country – Luxembourg.[96]

The outbreak of the COVID-19 pandemic has negatively impacted access to drug services in most countries – but it has also prompted welcome innovation. In response to the pandemic, a significant number of authorities relaxed existing regulations on prescription and dosing for take-home OAT, thus facilitating access to, and retention in, low-threshold treatment. For instance, many European states expanded the duration and quantities delivered to clients registered for take-home OAT programmes,[97] and countries like India,[98] amongst many others, approved take-home OAT for the first time. Regulations on supervised consumption or urine testing have also been relaxed. Beyond the pandemic, these innovations should be preserved, expanded, and encouraged where they have not yet taken place.

With regards to other forms of therapy, for instance for dependence on stimulant drugs such as methamphetamines, research and treatment options remain severely limited, albeit growing thanks to the work done by civil society and community-led organisations active in harm reduction.[99] This is despite the fact that the 2020 World Drug Report concluded that stimulant use is 'on the increase', in particular in the Americas and Southeast Asia.[100]

## Involuntary treatment and human rights violations

The imposition of forced drug treatment on people who use drugs is still prevalent in all regions of the world, ranging from court-issued mandatory treatment orders in Europe, to compulsory detention centres in Southeast Asia, or the involuntary internment of people who use drugs in privately-run drug 'rehabilitation' centres in Latin America.

> **"The vast majority [of people who use drugs] report that the drug services offered are related to evangelical churches, where they are forced to decorate parts of the Bible and study religion. Some of them have very questionable educational methods, such as forcing people to dig their own graves, since death would be where drugs are taking them. Many people are also forced to work in abusive environments, asking for donations in the street, with daily targets and physical punishments in case these are not achieved. We also serve LGBTQ+ people who, when accessing these services, have had their hair cut and clothes changed to perform the gender befitting the sex of birth."**
>
> **Maria Angélica Comis, Centro de Convivência É de Lei, Sao Paulo, Brazil**[101]

The weak language used in the Outcome Document´s paragraph 1.j, which only 'encourages' voluntary treatment, is strikingly at odds with existing evidence of the effectiveness of voluntary, community-based treatment.[102] Informed consent is also integral to the right to health, as well as to several rights connected to self-determination and personal autonomy under the UN human rights regime.[103]

One of the most harmful forms of forced treatment is the administrative detention and compulsory 'treatment' of people who use drugs in state-run facilities commonly known as 'compulsory drug detention centres' (CDDCs). CDDCs are prevalent across Southeast Asian countries, with reports of a total of over 400,000 people in administrative detention for drug use in 2017.[104] In most cases, administrative detention involves various forms of punishment that constitute torture or ill-treatment. These include corporal punishment such as beatings, flogging or whipping, which have been reported in Cambodia, China, Malaysia, Thailand and Vietnam;[105] forced and/or unpaid labour, which has been principally reported in Vietnam, but also in China and Cambodia;[106] and the denial of appropriate medical care. The so-called 'drug rehabilitation programmes' run in CDDCs are primarily abstinence-based,[107] and in many cases lacks any kind of scientific basis, as they revolve around involuntary detention and military-style discipline.[108] In 2012[109] and again in 2020,[110] twelve UN entities including the UNODC, WHO, UNAIDS and the Office of the High Commissioner for Human Rights (OHCHR), called for the immediate closure of CDDCs. However, the number of people detained in these centres has in fact increased in recent years, principally in Cambodia, Vietnam and Thailand.[111]

In an entirely different cultural and political context, five US states allow for the detention and involuntary treatment of pregnant women who use drugs on the basis of child protection or public health and safety laws.[112] Besides constituting a form of arbitrary detention, the threat of criminalisation also discourages women from seeking voluntary drug treatment and healthcare during pregnancy.[113]

In a wide array of countries[114] such as Brazil, India, Iran, Mexico or Nepal, people who use drugs are routinely interned against their will in private 'rehabilitation' centres. While comprehensive data on the number of centres that exist can be hard to obtain, in countries like Brazil this is a thriving industry funded, in part, by the government.[115] An estimated 35,000 people are held in irregular, uncertified and unsupervised drug treatment centres in Mexico, including thousands of women and girls, frequently with experiences of serious trauma and violence.[116] As is the case for CDDCs, many of these private centres run treatment programmes are abstinence-based and dismiss evidence-based interventions, such as OAT.[117] The involuntary apprehension and internment – in other words, kidnaping – of people who use drugs in private centres, often at the request of relatives, guardians or public authorities, has also been documented, in countries from Russia[118] to Guatemala.[119] Reports of torture and ill-treatment are rife, ranging from confinement in unhygienic conditions to painful or coercive rehabilitation techniques, in some cases leading to death.[120] Public authorities are responsible for these abuses, either because they directly fund such centres, because they are unable or unwilling to supervise them, or because they fail to provide alternative public services.[121]

> **"Looking back it was terrible... a very terrible experience. It's a pretty horrible 10 days. We were counting down the days every single day. I guess I could say that most people there are poor. It's as if the centre was built specifically for them. But if you ask me whether they deserve this or not, I don't think they deserve to be in here no matter what their social status is."**
>
> **21-year-old young adult that underwent 'drug rehabilitation' in a centre run by the military in Thailand**[122]

Mandatory or quasi-compulsory drug treatment is widely used in many criminal legal systems in the Global North, commonly as an alternative to incarceration or within a diversionary scheme.[123] For instance, a recent study of criminal laws in the EU found that, in 17 out of the – then – 28 legal systems under review, courts could issue mandatory drug treatment orders, and 15 countries allowed for the suspension of sentences followed by treatment.[124] Even in the best of cases, this practice is problematic, as evidence suggests that compulsory treatment is less effective than voluntary interventions,[125] and that it is frequently associated with violations of privacy through the use of registries and drug testing[126] (more information about drug courts is available below). Furthermore, in some cases people who are mandated to follow drug treatment are only offered one type of therapy regardless of their personal circumstances and typology of drug use – for instance, in the case of Sweden the abstinence-based 12-steps therapy.[127]

# 2.3 Access to controlled substances for medical and scientific use

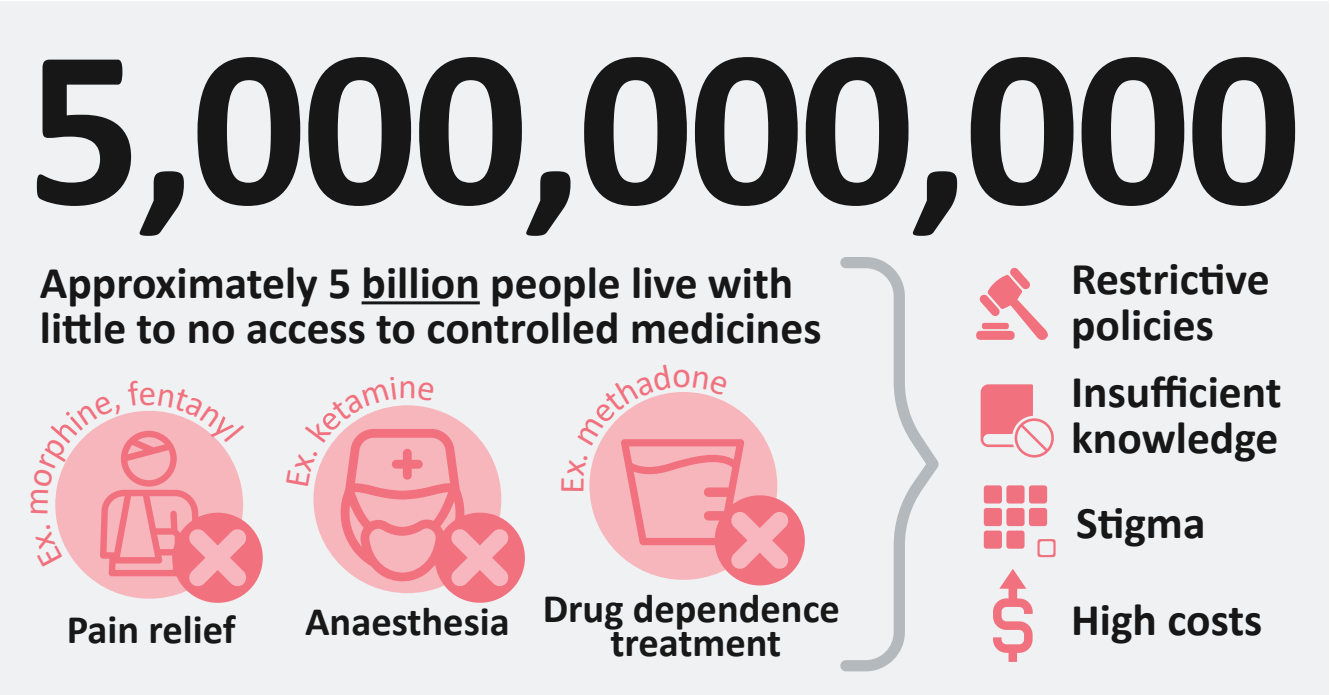
**Relevant UNGASS recommendations:**

- Paragraph 2.a. 'Consider reviewing (…) domestic legislation and regulatory and administrative mechanisms (…) with the aim of simplifying and streamlining those processes and removing unduly restrictive regulations and impediments, where they exist, to ensure access to controlled substances for medical and scientific purposes, including for the relief of pain and suffering'.
- Paragraph 2.b. 'Strengthen, as appropriate, the proper functioning of national control systems and domestic assessment mechanisms and programmes (…) to identify, analyse and remove impediments to the availability and accessibility of controlled substances for medical and scientific purposes.
- Paragraph 2.d. 'Address, at the national and international levels, issues related to the affordability of controlled substances for medical and scientific purposes, while ensuring their quality, safety and efficacy'.
- Paragraph 2.e. 'Take measures, in accordance with national legislation, to provide capacity building and training, (…) on adequate access to and use of controlled substances for medical and scientific purposes, including the relief of pain and suffering,'
- Paragraph 2.f. 'Develop national supply management systems for controlled substances that comprise selection, quantification, procurement, storage, distribution and use, strengthen the capacity of competent national authorities to adequately estimate and assess the need for controlled substances'
- Paragraph 2.g. 'Continue to regularly update the Model Lists of Essential Medicines of the World Health Organization'.

Various experts, policy makers, and advocates have long criticised the UN drug control system for its disproportionate emphasis on prevention and criminal justice measures against 'diversion' and/or 'abuse' of controlled substances.[128] This is contrary to one of the key objectives of the global drug control system itself, namely to ensure the accessibility and availability of substances needed for medical and scientific uses.[129] Such measures have left approximately five billion people around the globe with little to no access to controlled medicines for pain relief, anaesthesia, as well as for the treatment of drug dependence.[130] In 2015, the INCB reported that 17% of the world population (mainly in affluent countries) consumed 92% of morphine produced globally, whereas 75% of the world population had little to no access to morphine for pain relief. The situation was much worse for people living with AIDS in Sub-Saharan African and Asian countries, as well as for rural and poor communities in general.[1341] Three years later, the INCB noted that 'global disparity and imbalance remain evident'. Despite legislative, regulatory changes, as well as other improvements reported by authorities, the number of medical professionals who can prescribe opioid analgesics remains limited.[132] In 2020, the WHO also noted that lack of access to opioid medications – due to 'unnecessarily restrictive regulations' – continues to impede access to palliative care. As a result, globally, the percentage of people who receive the palliative care they need is as low as 14%.[133]

Civil society organisations and other advocates have pushed policy makers at all levels to adjust drug control mechanisms for the sake of medical access. However, this 'evolutionary process' takes time and will regrettably continue to leave patients with little to no access to the medicines they need, since 'governments must increase the demand for, and supply of "narcotic drugs for medical and scientific purposes" to increase access within their health systems, when for decades they have fought to reduce both demand and supply'.[134]

A recent development has shown the significance of the continued lack of balance between restrictions and accessibility at the policy making level. In 2019, the WHO withdrew two important guidelines related to balance in national policies on controlled substances and pain relief medicines for children with medical illnesses.[135] In response, a group of civil society organisations criticised the WHO's move. Referring to several Global North countries where the non-medical use of opioids is relatively more prevalent, organisations endorsing the statement 'disagree[d] that the particular situation of a few countries should drive decisions that may have a negative impact on global health, especially when such inequity already exists




in access to controlled medicines for the relief of serious health related suffering in low income settings'.[136] In February 2021, the WHO finally published a new guideline concerning the management of chronic pain in children. Though deserving positive support, the document is once again dominated by narratives of prevention of 'abuse' of opioids – leading the International Association for Hospice and Palliative Care to express concerns that 'many children will be cut off from access[ing]' opioid treatment essential to treat their chronic pain.[137]

The UNGASS gave unprecedented visibility to this critical issue, and the Outcome Document dedicates, for the first time in a high-level document on drugs, an entire chapter to controlled medicines. This chapter includes detailed recommendations aimed at 'addressing existing barriers… including those related to legislation, regulatory systems, healthcare systems, affordability, the training of healthcare professionals, education, awareness-raising, estimates, assessment and reporting, benchmarks for consumption of substances under control, and international cooperation and coordination' (paragraph 2). This section of the Outcome Document is particularly useful as national drug legislations and policies play a significant role in limiting access to internationally controlled medicines.

The problem of accessibility and availability predominantly affects the world's poorest, and hence should be understood in the broader context of economic inequality.[138] For example, a study published by the Journal of Global Oncology shows that the median price for oral morphine tablets is nearly six times lower in high-income countries than in low- and middle-income countries. In Mexico, one month of injectable morphine is 'several times the minimum wage in Mexico'.[139] Although controlled medicines are more widely accessible in the Global North, Doctors Without Borders reported that even Europeans are 'increasingly struggling to access the medicines they need because of rising medicine prices', much of which is due to the growing scale of profit-maximising activities of pharmaceutical corporations.[140]

## Updating lists and guidelines on essential medicines

Since the 2016 UNGASS, the WHO Model List of Essential Medicines was updated twice, in 2017 and 2019. The latest additions include several anti-TB and anti-retroviral medications. A study published in 2019 by the WHO Bulletin compared the 2017 WHO Model List of Essential Medicines to national lists of essential medicines in 137 countries, showing that 'most medicines (1248; 60%) were only listed by no more than 10% (14) of countries'. The study also suggests a positive relationship between countries' healthcare expenditures and the number of medicines covered in their national lists (which in some cases include medicines which are not in the 2017 WHO list), though a few exceptions can be observed, for example in Sweden and Syria. Positively, naloxone was included in the national lists of 117 countries, or 85% of the countries studied.[141]

Another study using INCB data from 2015 to 2017, and published in 2020 by the BMJ Global Health, focused solely on opioids and their medicinal status

## Box 1 Mexico's ongoing lack of access to prescription opioids for the poor

In June 2015, Mexico adopted regulatory changes to its prescription and dispensing of opioid analgesics in response to concerns that the old system was depriving people with advanced illnesses from accessing essential pain medication. The new system allowed physicians to use an electronic prescription system for opioid medicines. The same year, the Mexican government adopted an inter-agency agreement on palliative care, making it mandatory for medical schools to include it in their curricula.

Despite these positive developments, the scale of implementation has been limited so far.[142] A study published in the Lancet[143] showed that between 25 June 2015 and 7 October 2019, opioid dispensing rates did increase. However, in 2019 the INCB still ranked Mexico 104th out of 180 countries in terms of estimated opioid consumption. In addition, the study showed that states with a higher socio-economic status registered higher opioid dispensing rates than those with lower socio-economic status. This ongoing disparity in access to pain medication was explained by improved access to large hospitals in large metropolitan areas, the costs associated with stocking and storing opioids for pharmacies located in poorer areas, and differences in cultural perceptions about pain and its treatment, among other reasons.[144]

A 2020 civil society report also showed inconsistent access to methadone for people dependent on opioids across the country, being mostly available in private centres, rather than public facilities. In addition, several methadone clinics closed down in several Mexican cities since 2017, including in Ensenada, Baja California, Mexico City, Ciudad Juarez, Chihuahua and Mexicali. And although methadone was included in the basic healthcare sector as an essential medicine in 2017, its access remains severely limited as only one laboratory in the country is authorised to produce it, and importation is highly restricted and time consuming.[145]

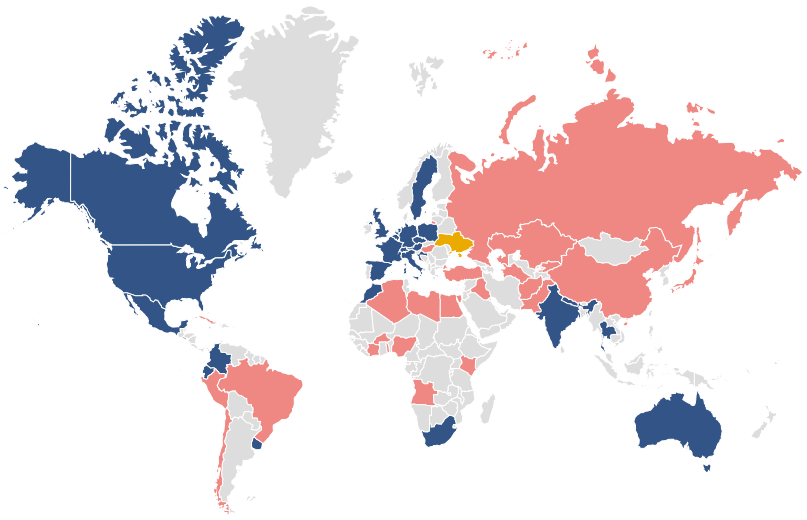
## Case study

Anton was 37 years old from Kaliningrad city, living with hepatitis C and dependent on opioids since 2000. He tried abstinence-based drug treatment methods available in Russia with no long-lasting remissions (more than 50 attempts of outpatient treatment, and 11 attempts of in-patient treatment). In August 2019, Anton was charged with possession of opioids along with four fellow people who use drugs. In June 2020, the Russian Ministry of Health officially refused him access to OAT. By August 2020, three of five accused died (one overdosed, one committed suicide in pretrial detention, one died soon after compassionate release from pretrial detention). In September 2020, Anton started suffering from liver failure due to cirrhosis. Because hospitals were busy with COVID-19 patients, and because of Anton's drug use, hospitals refused to accept him. On 29 November 2020 Anton died. His wife is currently pursuing the case under national law, and once all domestic remedies are exhausted, she will bring his case to the UN Human Rights Committee.[146]

in 137 countries, and showed that most national lists of medicines were outdated, with a median publication date of 2011 – at least several years prior to the 2016 UNGASS. The study concluded that the inclusion of opioids in national lists (such as codeine, fentanyl, and methadone) did not necessarily correlate with the domestic consumption of opioids. This serves as an important lesson that the inclusion of medicines in national lists does not necessarily result in higher accessibility and consumption, thereby raising questions regarding the effectiveness of domestic lists and related policies concerning essential medicines.[147]

### The global effort to remove barriers to access and address global disparity

The UNGASS commitment to remove barriers to access to controlled substances for medical and scientific purposes has translated into various policy documents and events at the regional and international level, but is yet to bring significant change to the situation on the ground. For example, 'access to and availability of controlled substances facilitated for medical and scientific purposes while preventing their diversion' is one of the main pillars



## REMOVAL OF CANNABIS FROM SCHEDULE IV
## VOTE AT THE CND 63RD SESSION (RECONVENED)

27 Member States out of the 53 members of the Commission voted to remove cannabis from Schedule IV of the 1961 Single Convention on Narcotic Drugs. This formal, and long overdue, recognition of the medical usefulness of cannabis (including in herbal form) should facilitate much-needed medical provision and further research.

**YES**

1. Australia
2. Austria
3. Belgium
4. Canada
5. Colombia
6. Croatia
7. Czech Republic
8. Ecuador
9. El Salvador
10. France
11. Germany
12. India
13. Italy
14. Jamaica
15. Mexico
16. Morocco
17. Nepal
18. Netherlands
19. Poland
20. South Africa
21. Spain
22. Sweden
23. Switzerland
24. Thailand
25. United Kingdom
26. United States
27. Uruguay

**NO**

1. Afghanistan
2. Algeria
3. Angola
4. Bahrain
5. Brazil
6. Burkina Faso
7. Chile
8. China
9. Côte d'Ivoire
10. Cuba
11. Egypt
12. Hungary
13. Iraq
14. Japan
15. Kazakhstan
16. Kenya
17. Kyrgyzstan
18. Libya
19. Nigeria
20. Pakistan
21. Peru
22. Russia
23. Togo
24. Turkey
25. Turkmenistan

**ABSTENTION**

1. Ukraine

of the 2019-2023 African Union Plan of Action on Drug Control and Crime Prevention. This pillar covers objectives and activities to 'address barriers' to availability and accessibility by engaging with pharmaceutical associations, governments, and civil society organisations, as well as by training healthcare staff and considering 'local provisions to increase the local production of controlled substances and plants for scientific and medical use, in line with the international drug conventions'.[148] Similarly, the EU Drug Strategy for 2021-2025 includes, as a priority area, the need to 'Provide, and where needed, improve access to, availability and appropriate use of substances for medical and scientific purposes'.[149]

At the 63rd session of the Commission on Narcotic Drugs (CND) in March 2020, representatives of several governments explained that a variety of actions had been taken to meet the 2016 UNGASS recommendations in tackling barriers to medicines at the national and global level, such as Australia's provision of AUD 60,000 for a three-year programme aimed at reducing 'global disparity'.[150] Although this commitment from Australia is to be welcome, this sum is direly low to address the ongoing crisis. That same week, the CND adopted Resolution 63/3 in support of 'promoting awareness-raising, education and training as part of a comprehensive approach to ensuring access to and the availability of internationally controlled substances for medical and scientific purposes and improving their rational use'. The resolution contains positive elements on accessibility, affordability, references to people's right to the highest attainable standard of health, prevention of marginalisation and stigma, and the importance of palliative care. However, the emphasis on 'diversion' and 'abuse' remains notable.[151] Similar discussions took place in October 2020 at the third CND thematic intersessional meeting on health, during which representatives of countries, regional groups, UN experts and civil society gathered and highlighted recent efforts to address the global disparity in access to controlled medicines.[152]

Such political commitments at the international level appear at odds with the situation on the ground. In fact, since 2016 little to no attention has been given to the lack of availability, accessibility, and affordability of controlled medicines, including in countries where opium is cultivated, such as in Colombia, India, and Afghanistan.[153] Meanwhile, though included in the WHO Model List of Essential Medicines, methadone and buprenorphine – used in OAT – remain prohibited in various countries, including in Egypt, Jordan, Russia, Saudi Arabia, Syria, Turkmenistan, Uganda and Uzbekistan.[154]

## December 2020: UN symbolically recognises the medicinal value of cannabis

In 2019, the WHO released its recommendations to reschedule cannabis and cannabis-related substances, based on the WHO Expert Committee on Drug Dependence (ECDD)'s first-ever critical review of cannabis and cannabis-related substances.[155] In its report, the ECDD notes that various scientific studies have proved that cannabis carries therapeutic potential to treat muscle spasticity associated with medical conditions like Multiple Sclerosis, among others.[156] In December

## Box 2 Civil society led advocacy for access to medicinal cannabis in Indonesia

Cannabis is placed under Schedule I in Indonesia's narcotics law, meaning that the substance can only be used for scientific purposes. This highly restrictive status of cannabis has long prevented people from legally accessing cannabis-based medicines, such as cannabis oil. In 2017, the death of Yeni Riawati, whose husband was jailed after cultivating cannabis to treat her illness, sparked a public debate around cannabis prohibition in Indonesia. Since then, more and more activists, civil society groups, and public figures have spoken out in favour of reform.[157] In November 2020, three women joined forces with civil society groups to challenge the narcotics law – particularly Articles 6 and 8, which assert that Schedule I substances can only be used for scientific purposes – by submitting a request for a judicial review at the Constitutional Court. The three women are mothers of children whose illnesses can potentially be treated by cannabis. In support of these efforts, advocates are arguing that the current prohibition of medicinal cannabis contradicts the purpose of the narcotics law as well as the Indonesian Constitution, both of which serve as instruments which supposedly support public health and people's access to medicines.[158]

2020, the CND finally voted to adopt the WHO recommendation to remove cannabis from Schedule IV of the 1961 Convention (a Schedule reserved for the most harmful drugs whose 'liability is not offset by substantial therapeutic advantages'[159]). The removal of cannabis from Schedule IV does not result in significant changes with regards to control measures, yet it constitutes a long overdue symbolic acknowledgment of cannabis' medicinal potential at the UN level.[160] This should pave the way for more countries to adapt national policies regarding medicinal cannabis. In fact, prior to the adoption of recommendation 5.1 in December 2020, the Argentinian government had already cited the WHO's critical review in its decree allowing sales and personal cultivation of cannibis for medical use.[161]

> **"With Thailand being the first country in Southeast Asia to legalise medical cannabis in 2019, it has moved light-speed ahead of its neighbours in its view of cannabis from being 'a dangerous narcotics drug' to 'an accessible medical plant'. Thailand is moving in the right direction, but there is still a gap in understanding and a deep-rooted divide between the haves and the have nots in terms of levels of access."**
>
> **Kitty Chopaka, Independent Drug Legalisation Advocate, Thailand**

Dozens of additional countries have also adopted laws and/or policies to allow access to cannabis-based medicines since the 2016 UNGASS. These include countries in the Americas such as Peru, Bolivia, and Mexico (2017), Asian countries such as Thailand (2018), South Korea (2019) and even the Philippines (2016), European countries such as Poland (2017), Slovenia (2018) and Denmark (2018), as well as South Africa (2019).[162] In this regard, Thailand is the only country in the world that has legally incorporated traditional medicine and healing systems in its medicinal cannabis regulation.[163]

# Notes

# Part 3

## A development-oriented approach

# 3.1 Moving towards a sustainable development rhetoric

**Relevant UNGASS recommendations:**

- Paragraph 7.a. 'Target the illicit cultivation of crops (…) by implementing comprehensive strategies aimed at alleviating poverty and strengthening the rule of law, accountable, effective and inclusive institutions and public services and institutional frameworks, as appropriate, and by promoting sustainable development aimed at enhancing the welfare of the affected and vulnerable population through licit alternatives'.
- Paragraph 7.b. 'Encourage the promotion of inclusive economic growth and support initiatives that contribute to poverty eradication and the sustainability of social and economic development'.
- Paragraph 7.d. 'Consider elaborating and implementing comprehensive and sustainable alternative development programmes, including preventive alternative development, (...) ensuring the empowerment, ownership and responsibility of affected local communities, including farmers and their cooperatives (…)'.
- Paragraph 7.h. 'Consider strengthening a development perspective in drug policies to tackle the related causes and consequences of illicit cultivation, manufacture, production of and trafficking in drugs by, inter alia, addressing risk factors affecting individuals, communities and society'.
- Paragraph 7.i. 'Urge relevant international financial institutions, UN entities, NGOs and the private sector, as appropriate, to consider increasing their support, including through long-term and flexible funding, for the implementation of comprehensive and balanced development-oriented drug control programmes and viable economic alternatives'.
- Paragraph 7.j. 'Encourage the development of viable economic alternatives, particularly for communities affected in urban and rural areas, ensure that both men and women benefit equally from them including through job opportunities, improved infrastructure, basic public services and access and legal titles to land;.
- Paragraph 7.k. 'Consider the development of sustainable urban development initiatives for those affected by illicit drug-related activities to foster public participation in crime prevention, community cohesion, protection and safety (…)'.

The 17 Sustainable Development Goals (SDGs) were adopted by all 193 UN member states in September 2015. These Goals signalled a global commitment to 'end all forms of poverty, fight inequalities and tackle climate change, while ensuring that no one is left behind'.[164] The adoption of the SDGs positively influenced drug policy discussions in the run up to the UNGASS, shaping a more inclusive and comprehensive approach to drugs.

The Outcome Document dedicates a full chapter on 'development-oriented balanced drug control policy'. [165] It offers a more comprehensive interpretation of the narrow 'alternative development' approach that has been traditionally promoted in drug control debates. For example, the UNGASS Outcome Document calls for measures 'ensuring the empowerment, ownership and responsibility of affected local communities, including farmers and their cooperatives, by taking into account the vulnerabilities and specific needs of communities affected by or at risk of illicit cultivation' (paragraph 7.d).

In recent years, the global discourse around supply-side policies has gradually transformed – from an eradication-focused approach to a greater emphasis around sustainable development and livelihoods. Drawing wording from the Outcome Document, the 2019 Ministerial Declaration also promotes 'the implementation of long-term comprehensive and sustainable development-oriented and balanced drug control policies and programmes'.[166]

The failures of, and human rights violations associated with, forced eradication measures – especially when such measures are implemented without other viable livelihood options in place – have greatly contributed to this changing discourse, as well as the formulation of national policies following the UNGASS, for instance the inclusion of 'sustainable alternative development for opium farmers' in Myanmar's 2018 National Drug Control Policy.[167] Another sign of this shift in narrative is the increasingly frequent use of development-focused terms such as 'food security', 'social integration', and 'gender' in national and local drug policy discussions following the 2016 UNGASS.[168]

# FIVE YEARS AFTER UNGASS | DEVELOPMENT


Yet another and possibly most notable example of this shift in narrative is the positive formulation of development issues associated with drug policy within the International Guidelines on Human Rights and Drug Policy, which have been endorsed by the OHCHR, UNAIDS, the United Nations Development Programme (UNDP) and WHO.[169] Presented at the 62nd session of the CND in 2019, the International Guidelines serve as the first global and intergovernmental document outlining 'specific human rights issues that are applicable to drug policy', including by 'establishing long-known linkages between development deficits and the rights of people who cultivate illicit crops'.[170] In addition, from 2018 to 2020, the CND adopted three resolutions on 'alternative development' and 'development-oriented, balanced drug control policy addressing socio-economic issues'.[171]

## 3.2 ...With limited progress on the ground

Nevertheless, this changing – and improved – discourse on development and drug policies has mainly played out at the international level and, with rare exceptions, has yet to be implemented at the country level. For instance, the principle of adequate sequencing – in which eradication measures should only be carried out when alternative livelihoods are already in place and available for farmers – remains largely neglected in practice, despite being enshrined in the International Guidelines on Human Rights and Drug Policy, the UN Guiding Principles on Alternative Development,[172] as well as highlighted by several intergovernmental bodies.[173] It is concerning to see that the lack of attention given to this key principle seems to have worsened in today's alternative development programmes, when compared with projects in the 1980s, despite the shifting discourse at the international level.[174]

More recently, the government of Colombia has announced its intention to resume the aerial spraying of coca, going hand-in-hand with ongoing, militarised forced eradication efforts. This risks undoing years of peacebuilding and development efforts crystallised in the Colombian peace accord and the National Comprehensive Program for the Substitution of Illicit Crops (locally known as PNIS). Launched in 2017 and included in the Peace Agreement, PNIS created a process whereby coca farmers agreeing to voluntarily uproot coca bushes would receive government-sponsored infrastructure development, training and financial assistance. PNIS was far from ideal as it relied on voluntary eradication as a *precondition* for developmental assistance, and in this context, it is important to note that the government never ceased manual eradication efforts, even in some areas where communities had signed voluntary eradication agreements. Nonetheless, PNIS was regarded as 'transformative', and nearly 100,000 families were involved in the programme.[175] In 2018, however, changes in the Colombian government undermined PNIS, along with its financial, political, and administrative resources. To date, less than 1% of the families participating in this programme have received support for productive projects aimed at replacing the income coming from their coca crops. Shortly after the change in government, militarised eradication campaigns were stepped up and intensified, even during the COVID-19 pandemic, resulting in violence and deaths of people in rural areas, including in areas like Cauca, Catatumbo, Nariño, Antioquia and Córdoba, among other regions, where PNIS had previously presented hope for peace and welfare for local communities.[176]

> **"Starting in 2021, seven UN Special Rapporteurs asked President Duque not to return to aerial spraying with glyphosate due to the serious impacts this will have on the country's population and ecosystems. But the Colombian government has refused to respond to the Rapporteurs' arguments. At least 75 human rights leaders linked to voluntary crop substitution processes have been murdered since the signing of the Peace Agreement. Nine other coca farmers were killed amid forced crop eradications during the time of the pandemic. In 2020, more than 120 clashes were recorded between coca growers opposing the forced eradication of crops and the troops of the Ministry of Defense."**
>
> **Pedro Arenas, Corporación Viso Mutop[177]**

More generally, the manual eradication of coca fields has increased in the past three years, according to the 2020 World Drug Report.[178] Eradication measures also continue in cannabis growing areas – from Albania to Bangladesh,[179] eSwatini[180] and Mexico.[181] However, for years, evidence has shown the fundamentally flawed logic of crop eradication – such efforts only result in reduction in the levels of cultivation in the mere short term. In the long run, eradication efforts simply pave the way for changes in cultivation patterns (also known as the 'balloon effect'), whether it concerns the territories, the actors, and the types of substances[182] produced and distributed along the production and trade lines.[183]

In most countries in the world where crops are grown for illegal markets, far greater resources are dedicated to attempting to reduce cultivation,

rather than to provide alternatives to small farmers. These programmes disproportionately impact the world's poorest farmers, pushing them deeper into poverty, while fostering human rights abuses and generating social unrest and violence. Indeed, sustainable development and human rights-oriented drug policy approaches are frequently overshadowed by repressive approaches, with 'the UN drug control conventions hav[ing] an inherent bias towards criminalisation and repressive law enforcement'.[184] Furthermore, alternative development programmes are usually carried out with the primary aim of reducing the scale of the illegal drug market, rather than improving community well-being and/or addressing the underlying socio-economic issues faced by affected communities – despite the commitments made in paragraphs 3.b, 5.v and 7.b of the UNGASS Outcome Document. [185]

Thailand's decades-long development project in Doi Tung perhaps serves as the only positive example of crop reduction policies which prioritise sustainable development and livelihoods for communities. Central to this project is the principle that efforts to reduce poppy cultivation should be planned and conducted in coordination with local communities, and *only* when alternative livelihoods generate sufficient and sustainable income. According to a 2017 report, between 1988 and 2016, household income in Doi Tung rose by 20 times, while opium cultivation is said to no longer exist in the region.[186] In this regard, it is important to note that the Thai Doi Tung project began as early as the 1980s.

Bolivia's coca community control programme is another positive example worth highlighting, though it was disrupted for one year by the de facto government that took power in November 2019.[187] Implemented in 2006, the programme was based on the 'coca yes, cocaine no' principle, allowing coca growers to cultivate limited amounts of coca for subsistence and to supply the domestic legal coca market. The programme crucially relied on participatory models to meaningfully involve farmers' unions and local communities in self-regulating coca cultivation, as well as in designing public services and development initiatives. Other important pillars were the prioritisation of public work and social services, reforestation and other environmental sustainability projects, and 'development assistance without coca eradication as a prerequisite'.[188]

## 3.3 Complex realities call for comprehensive and socially just models of sustainable development

The inclusion of development-oriented goals, and the SDGs in particular, in the UNGASS Outcome Document signals a long-awaited acknowledgement and understanding that addressing socio-economic inequalities should be central to the design and implementation of drug policies. However, 'the integration of drugs and development comes at a time when the record of development is – like drug policy – coming under critical scrutiny'.[189] Central to this scrutiny is the fact that 'development' and 'sustainable development' are often rather 'ambiguous in concept and practice', depending on projects that are not only market-focused, but also supportive of programmes and structures which undermine the genuine emancipation of marginalised communities.[190]

A 2020 report highlights the many challenges faced by opium farmers involved in livelihood programmes in Myanmar, through which coffee has been promoted by donors as a legal and economically attractive alternative to opium.[191] However, it takes years for coffee plants to generate income (in contrast with several months in the case of opium), and farmers often receive too little financial support to cover the high costs of transporting coffee seeds[192] – not to mention the various difficulties faced by opium farmers residing in areas where eradication remains the norm, and where development assistance is scarce or non-existent.[193] In addition, alternative livelihood programmes in Myanmar require that farmers cultivate a minimum area of land to benefit from the programmes.[194] Such a requirement ignores the fact that many farmers (in Myanmar and other parts of the world) grow crops on unregistered and/or communal and public lands, partly due to the expansion of (state-sanctioned) land grabs and extractive industries (see section on indigenous and cultural rights).[195]

> **"I started a coffee plantation two years ago. I haven't gotten any money from it yet. So, I continue opium farming to support my family."**
>
> **Male opium farmer in Myanmar[196]**

More recently, in February 2021, plummeting coffee prices have left Peruvian farmers impoverished and/or debt-ridden, thereby pushing many of them back to coca cultivation. This recent growth in coca cultivation has prompted the Peruvian government to respond with measures of forced eradication and violence, with devastating human rights consequences for growers.[197]

> **"DEVIDA (the Peruvian drugs agency) is supposed to help us replace coca but they spend 80% of their budget on salaries and cars. By the time it gets to us, all we receive is a sack of fertiliser and a machete – that's not development."**
>
> **Male coca farmer in Peru[198]**

The experiences of farmers in Myanmar and Peru illustrate the complex realities of communities involved in illegal cultivation, especially for those who have also opted for alternative and legal, but less viable, livelihoods. The fluctuating and/or relatively lower prices of legal agricultural commodities, combined with limited access to markets and numerous barriers to receiving assistance and accessing public services, constitute a significant challenge for farmers wishing to reduce their economic dependence on illegal cultivation. Moreover, as noted by some scholars,[199] many of the challenges involved in development-oriented drug policies relate to the lack of clarity and coherence with regard to the development and drug policy nexus, partly also influenced by the legacy of (failed) alternative development and crop reduction attempts.

Some countries and international donors have started to think creatively about how to leverage the cultivation of certain plants for legal purposes, in particular cannabis, which could potentially serve as legal livelihoods and development for rural communities. A 2021 report by the German-funded Global Partnership for Drug Policy and Development concluded that 'At international level, a change is becoming apparent in the way countries are dealing

with cannabis and cannabis products. More and more countries, including Germany, are adopting laws to regulate the medical use. This might increase the demand for legally cultivated medical cannabis and open up development potentials in regions in which cannabis has only been grown illegally to date'. The report notably recommends a 'Review of the feasibility and potential of medical cannabis as a legal value chain for Alternative Development in developing countries'.[200]

In Jamaica, the Cannabis Licensing Authority is currently developing an 'Alternative Development Project' in collaboration with the Westmoreland Hemp & Ganja Farmers Association and the St Elizabeth Maroon community, 'geared towards transitioning current illicit ganja farmers into the legal regulated industry'.[201] Though the process of implementation has been relatively slow, the project potentially serves as a promising pathway towards more inclusive models of sustainable development.

Importantly, the process of designing and implementing a sustainable development approach in drug policy has to take into account the complexity of drug markets and the wider (regional and global) context in which they exist. This means acknowledging the overlap between legal and illegal enterprises, channels, and activities – as well as the different kinds of actors involved. For example, a recent study in Sinaloa, Mexico shows that the poppy economy 'does not operate on the margins of the formal economy but, rather, benefits directly from it'. Regardless, it is fair to say that only a small percentage of the income and profits created in these contexts goes to those who are most exploited, such as small-scale farmers.[202]

## 3.4 Cultivation, drug control and environmental degradation

Illegal cultivation is regularly associated with – and in some cases *does* contribute to – environmental degradation, including the overuse of water supplies, soil degradation and deforestation.[203] The UNGASS Outcome Document does highlight the need to address 'the consequences of illicit crop cultivation and the manufacture and production of narcotic drugs and psychotropic substances on the environment' (paragraph 7.b). Though rarely addressed, ecologically harmful practices in cultivation areas are often carried out precisely because eradication-focused policies (along with their direct or indirect impacts such as land grabs and displacement) continuously push growers to adopt more extreme cultivation and survival strategies in order to avoid enforcement measures.

Eradication campaigns not only destroy livelihoods and the environment, but can also trigger 'violent defensive reactions from cultivators and initiatives by cultivators to seek support and protection from insurgent groups, informal power holders and other non-state actors'.[204] Furthermore, it is worth noting that growers operating within criminalised spaces are less likely to follow environmental regulations (if they are in place), while 'public officials can be inconsistent in enforcing environmental norms on illegal or semi-legal plantations'.[205]

The Outcome Document promotes the inclusion of 'criteria related to environmental sustainability and other measurements in line with the Sustainable Development Goals' in development-oriented drug policies (paragraph 7.g). Since the 2016 UNGASS, little progress has been made in this regard. Morocco's inclusion of environmental standards (including references to regulations around planting rotation as well as on the use of fertilisers and pesticides) in its recently released medical cannabis bill[206] can potentially be seen as a positive step towards alleviating environmental degradation in the Rif region.[207]

## 3.5 Expanding development-oriented strategies to urban areas

Experts have increasingly voiced concerns over the narrow scope of alternative development projects and, to a certain extent, of other existing development programmes for drug control, which have mostly 'been confined to rural areas without engaging with the challenges presented by urban drug markets and synthetic substitution'.[208] The UNGASS focus on development-oriented drug policies for both rural and urban settings is therefore to be welcome (paragraphs 7.j and 7.k).

In both urban and rural areas across the globe, involvement in the supply-side of the illegal drug market, such as selling or transporting drugs, is predominantly attributed to poverty, as well as racial, ethnic, class, and gender inequalities, all of which are exacerbated by punitive drug laws.[209] Data in various countries show that drug law enforcement and incarceration disproportionately affect marginalised groups, including people living in poverty, migrants, women, people belonging to racial or ethnic minorities, as well as people who use drugs. This has been the case in numerous countries across continents, from the USA[210] to Latin American countries such as Argentina, Brazil, and Ecuador,[211] to Southeast Asian countries such as Indonesia, the Philippines and Thailand.[212]

Criminalisation and incarceration continue to be the dominant approach and thus – similar to the prevailing dominant practice of crop elimination in cultivation areas – continue to undermine the 'sustainable urban development' needed to address the underlying socio-economic inequalities that lead one to take part in the drug trade in the first place.[214] Besides, developments in countries like Mexico and the wider region have shown the interdependent relation between activities and actors in both urban and rural areas.[215]

Another important element to consider is the relationship between illegal drug markets and violence, including in urban settings. It is key to recall here that illegal drug markets are not inherently violent, and that 'violence is sometimes fuelled by law enforcement efforts', as has happened in the USA,[216] but also in Latin America and the Caribbean, particularly in the case of smokable cocaine markets in urban areas.[217]

> **"They came to my house,... knocked down doors,... I had my daughter with me. She said something I'll never forget: 'Mom, they're going to kill us'."**
>
> **Lidieth, arrested by the police, and then incarcerated for 5 years, 4 months for selling small quantities of drugs from her home in Costa Rica**[218]

### Case study

AJaya, 38, in the Philippines, decided to be a drug 'runner' (i.e. courier) when her daughter had an illness which required "3 injections per day, which cost PHP 10,500". She received PHP 500 for each successful delivery of shabu, and this allowed her to pay for her daughter's medical expenses throughout the five months of her illness.[213]

## 3.6 Looking towards long-term, sustainable development

Looking at the wider picture, many efforts to adopt programmes that focus more on the 'sustainable development' approach, ironically, still lack a long-term and sustainable vision and design. This reality stands in stark contrast with the (re)formulation of policy commitments at both the national and international level, from a more narrow 'alternative development' to 'alternative livelihoods and development-oriented drug policies'.[219] The lack of availability and accessibility of essential public services among communities facing marginalisation in both rural and urban areas also plays a role in undermining sustainable development. In the context of the SDGs, marginalised communities such as farmers and workers involved in the illegal drug trade often struggle to access 'good health and well-being' (SDG 3) and 'quality education' (SDG 4), among others.

### Case study

A nurse residing in a mountainous opium-growing village in Shan State, Myanmar, explains that she has to provide basic healthcare for 25 villages. The nearest hospital "is an hour away by scooter, which can easily turn into five hours in the rainy season", while access to education remains limited due to prevailing economic inequality, and the general lack of public services in the region.[220]

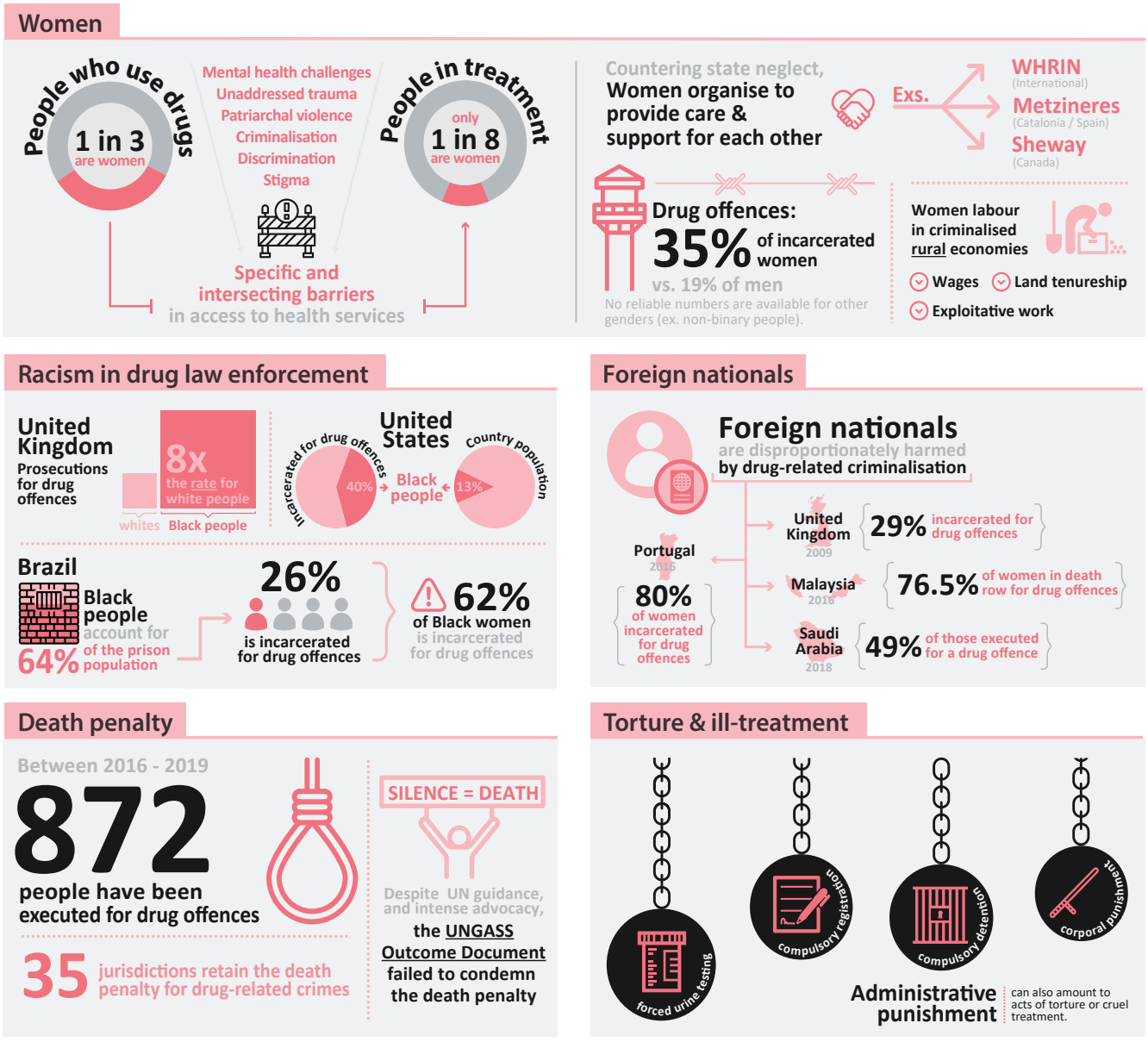
> **"If I didn't provide for my children, they would have died of hunger. It's the easy money that always conquers you, because you never think about the consequences in the moment. You only think of what you're going to bring home and give to them."**
>
> **J. sentenced for 5 years, 4 months for attempting to bring drugs into a prison in Costa Rica**[221]

In sum, when it comes to sustainable development approaches in drug policy, there has been little to no progress on the ground in the five years since the UNGASS. Criminalisation and eradication, combined with weak and incomplete efforts towards achieving the SDGs, remain the default approach to date. Looking forward, recommendation 7.h of the UNGASS Outcome Document aiming at 'strengthening a development perspective in drug policies' appears as urgent as the implementation of other development-oriented recommendations. A critical examination of current development concepts and practices, involving cross-sectoral collaboration (between drug policy, development, and other sectors), is crucial to achieving a form of 'sustainable development' that systematically addresses the complexity of the drug economy, and that truly benefits people and communities on the ground.

# Part 4

## An improved articulation of drug control and human rights

# FIVE YEARS AFTER UNGASS
# HUMAN RIGHTS & CRIMINAL LEGAL REFORM




For the first time in a high-level political document on drugs, the UNGASS Outcome Document includes an entire chapter dedicated to 'drugs and human rights, youth, children, women and communities', in which the international community reiterated its 'commitment to respecting, protecting and promoting all human rights, fundamental freedoms and the inherent dignity of all individuals and the rule of law in the development and implementation of drug policies'.

Accordingly, it is critical to assess progress made since the UNGASS in ensuring that all aspects of drug policies are developed, implemented and evaluated in accordance with obligations under national, regional and international human rights law.

In this context, one of the major achievements since the advent of the UNGASS has been the adoption of the International Guidelines on Human Rights and Drug Policy in March 2019.[222] The annual drugs omnibus resolutions have also consistently addressed human rights issues since the 2016 UNGASS,[223] while the 2019 Ministerial Declaration recognised 'responses not in conformity with… applicable international human rights obligations' as an ongoing challenge to be addressed for the next decade of drug control.[224] In Geneva, the Human Rights Council has become increasingly vocal in highlighting human rights abuses associated with drug policy (including on arbitrary detention, the death penalty and the Philippines),[225] the High Commissioner for

Human Rights has made strong statements condemning egregious human rights violations committed in the name of drug control,[226] and UN treaty bodies are paying increasing attention to drug-related matters in their country reviews (see more information below). At regional level, the EU Drug Strategy for 2021-2025 makes an explicit reference to the International Guidelines on Human Rights and Drug Policy;[227] and the Council of Europe has adopted its first resolution on drug policy and human rights;[228] while in the Americas, the Inter-American Commission of Human Rights has expressed ongoing human rights concerns over the impacts of harsh drug laws in fuelling prison overcrowding.[229]

While normative development since the 2016 UNGASS is strongly welcomed, it is yet to deliver real change for the individuals and communities impacted by drug policies – and drug control remains a major driver of rights violations worldwide, with victims and survivors being routinely denied effective remedy. This entrenched dynamic gives certain credence to the notion that, while punitive drug policies have failed in their stated purpose of reducing the scale of illegal drug markets, they have succeeded in targeting and controlling certain groups and communities.[230]

# 4.1 Women

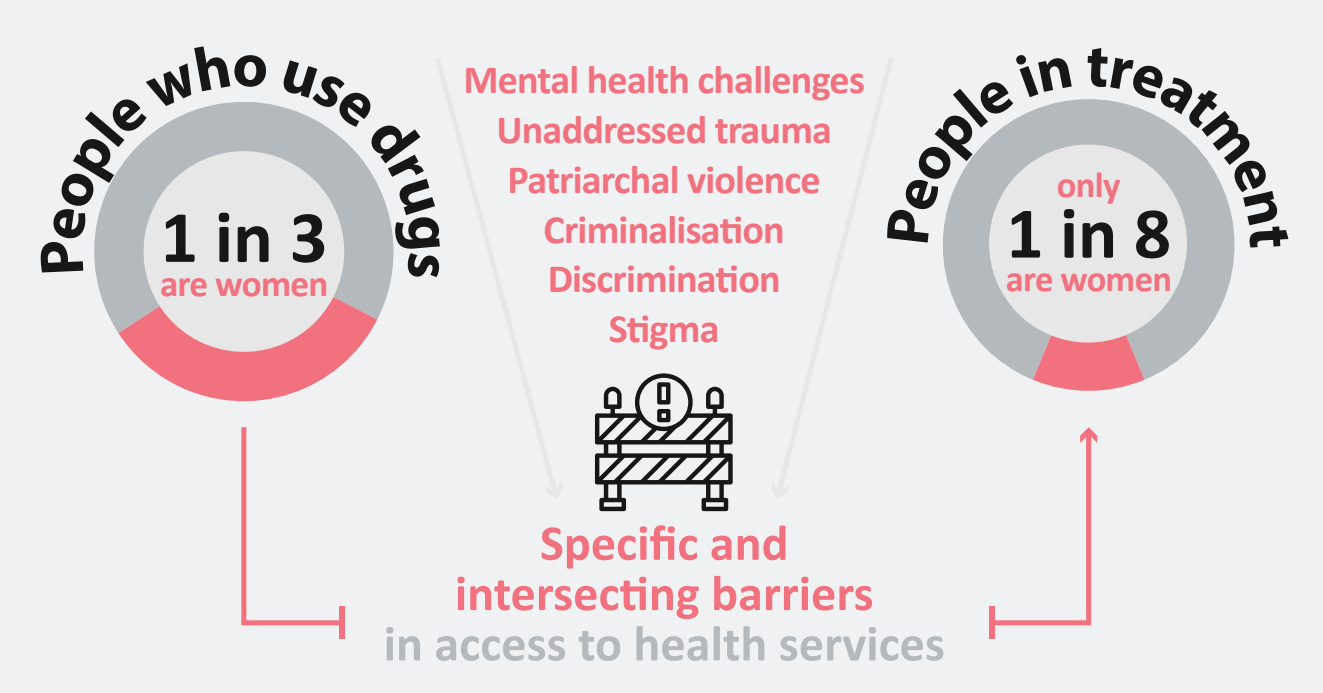
**Relevant UNGASS recommendations:**

- Paragraph 1.k. 'Ensure non-discriminatory access to a broad range of interventions, including psychosocial, behavioural and medication-assisted treatment, as appropriate and in accordance with national legislation, as well as to rehabilitation, social reintegration and recovery-support programmes, including access to such services in prisons and after imprisonment, giving special attention to the specific needs of women, children and youth in this regard'.
- Paragraph 4.b. 'Ensure non-discriminatory access to health, care and social services (…) and ensure that women, including detained women, have access to adequate health services and counselling, including those particularly needed during pregnancy'.
- Paragraph 4.d. Continue to identify and address protective and risk factors, as well as the conditions that continue to make women and girls vulnerable to exploitation and participation in drug trafficking, including as couriers, with a view to preventing their involvement in drug-related crime'.
- Paragraph 4.g. 'Mainstream a gender perspective into and ensure the involvement of women in all stages of the development, implementation, monitoring and evaluation of drug policies and programmes, develop and disseminate gender-sensitive and age-appropriate measures that take into account the specific needs and circumstances faced by women and girls (…)'.
- Paragraph 4.n. 'Encourage the taking into account of the specific needs and possible multiple vulnerabilities of women drug offenders when imprisoned, in line with the United Nations Rules for the Treatment of Women Prisoners and Non-custodial Measures for Women Offenders (the Bangkok Rules)'.

## Access to health services for women who use drugs

One of the major wins of the UNGASS Outcome Document was the level of visibility given to the specific needs of women in contact with the illegal drug market, as well as the inclusion of concrete recommendations to better address these needs. The Outcome Document recognises the dire lack of availability of, and access to, gender-sensitive health services for women who use drugs, with member states committing to ensuring that 'women, including detained women, have access to adequate health services and counselling, including those particularly needed during pregnancy' (paragraph 4.b). Access to harm reduction interventions for women who use drugs was also central to CND resolutions 61/4 and 62/6.

There has been a welcome shift in rhetoric on women who use drugs within the UN. The 2016 INCB Annual Report dedicated its thematic chapter to 'Women and drugs', notably highlighting the exceptionally high levels of stigmatisation faced by women who use drugs.[231] In 2018, the UNODC dedicated an entire booklet of its World Drug Report to the issue of 'Women and drugs'. In its analysis, the Office recognised the specific vulnerabilities faced by women who use drugs with regards to stigma and discrimination, gender-based violence, trauma and mental illness. The UNODC also reported that women who use drugs are more likely to contract HIV and other blood-borne infections than their male counterparts, because of gender power imbalances, the stigma associated with contravening their traditional role as mothers and caretakers, and the lack of gender-sensitive services.[232] The report concluded that the number of deaths attributed to drug dependence had 'increased disproportionately among women, with a 92 per cent increase in deaths attributed to opioid use disorders among women compared with a 63 per cent increase among men' over the past decade.[233] In addition, the OHCHR, in its 2018 report on the implementation of the UNGASS Outcome Document, stressed that women who use drugs continue to face 'high levels of violence and




harassment from law enforcement officers.[234] At the CND, UN member states adopted two resolutions on women and drugs following the UNGASS:

- Resolution 62/6. Promoting measures to prevent transmission of HIV attributable to drug use among women and for women who are exposed to risk factors associated with drug use, including by improving access to post-exposure prophylaxis[235] (2019)
- Resolution 61/4. Promoting measures for the prevention of mother-to-child transmission of HIV, hepatitis B and C and syphilis among women who use drugs[236] (2018)

> "For me It has been a journey of self-discovery, getting back my dignity as a human being, my self-esteem, self-image, the fact that I can reach out to my peers to provide support is a big thing for me, I can walk into a police station without fearing that I will be arrested, I can talk to apparent without feeling ashamed about how they see me. I have dealt with my insecurities and I am ready to live again."
>
> **A woman who uses drugs in Kenya shares her experience on how accessing harm reduction services has improved her quality of life[237]**

Here again, the shift in rhetoric has not been followed by meaningful change on the ground. Despite the increased recognition of the difficulties faced by women who use drugs, their access to health, care and social services remains severely limited, with little progress made since 2016. In its 2020 World Drug Report, the UNODC reiterated that 'while one in three drug users is a woman, women continue to account for only one in five or less people in treatment'[2238] – an estimate that the UNODC had already noted in its 2015 World Drug Report.[239] UNAIDS reached similar conclusions on availability of HIV services for women who use drugs in 2020, stating that 'Among the 14 countries that reported sex-disaggregated data to UNAIDS since 2015, just two achieved the recommended target of 40% coverage among men who inject drugs, and none had reached the target among women who inject drugs'.[240] In addition, although various UN agencies have highlighted the specific barriers faced by women who use drugs, including criminalisation and stigma, women who use drugs continue to be criminalised, fear of loss of child custody may deter mothers from accessing healthcare services, and pregnant women who use drugs may refuse to access sexual and reproductive health services in contexts where drug use during pregnancy incurs a prison sentence or compulsory treatment (as is the case, for instance, in various US states[241]).[242]

In the context of the COVID-19 pandemic, the UN Special Rapporteur on the right to health concluded that it was 'essential that gender-sensitive harm reduction services, non-judgemental sexual and reproductive health services, and domestic violence services are kept operational, and equipped to remain effective'.[243]

Women who use drugs and are deprived of their liberty are particularly at risk of health harms. The UN estimates that 50% of incarcerated women, as


opposed to 30% of men, have experienced drug dependence in the year prior to incarceration.[244] Injecting drugs in precarious and unhygienic conditions may present a high risk of HIV and hepatitis C infection and overdose,[245] while sharing smoking equipment is particularly risky for the transmission of viruses like tuberculosis and COVID-19. However, access to health services for women who use drugs in prison is highly restricted. In the limited number of countries where harm reduction and treatment services do exist in prison, they are generally only available for men.[246]

Positively, in many parts of the world, women who use drugs have risen to the challenge of coming together and mobilising to claim their rights and fill the vacuum left by government responses to provide life-saving care and support for themselves and their peers. Internationally, the Women and Harm Reduction International Network has mobilised women from all regions of the world to advocate for the expansion of harm reduction services for women who use drugs, and protect their human rights.[247] At local level, services like Metzineres in Barcelona, Spain, or Sheway in Vancouver, Canada, seek to empower women while offering harm reduction and shelter for women who use drugs, especially for those who have survived trauma, violence and incarceration.[248]

With regards to government responses, in its contribution to the upcoming report of the UN Working Group on Arbitrary Detention, Spain reported on its efforts to better integrate gender sensitivity in all its drug programmes and prevention and early detection of gender-based violence against women who use drugs. New drug strategies were also adopted in Argentina, Ireland, Lebanon and Myanmar which refer to various gender-sensitive programmes.[249] Although these efforts remain limited, they constitute important steps towards addressing the needs of women who use drugs.

## Women incarcerated for drug offences

Women are disproportionately imprisoned for drug-related offences – global data shows that 35% of women in prison, compared to 19% of men in prison, are incarcerated for drug offences.[250] This percentage increases drastically in Latin America and Asia, where women imprisoned for drug offences can constitute 50 to 80% of all women deprived of their liberty, with repressive drug laws being the main driver of female incarceration.[251]

> **"The judge says, 'You're not fit for society, you're not capable of living with your children'... But believe me, when you're alone with your three children... you can't say 'sorry, I can't feed you, I don't have work'... That's where I say, forgive me, but I'm going to go sell drugs one day, and that day I can go pay rent."**
>
> **Johana, incarcerated for 6 years 4 months for a drug offence in Colombia[252]**

The Inter-American Commission of Human Rights in particular highlighted the role of harsh drug laws and widespread use of pretrial detention in fuelling prison overcrowding, with particularly dire conse-

quences for women.[253] The UNODC also produced a Toolkit on gender-responsive non-custodial measures in 2020 in which it highlights the criminalisation of women who use drugs as a driver of incarceration.[254]

The UNGASS Outcome Document calls on member states to identify the risk factors that 'continue to make women and girls vulnerable to exploitation and participation in drug trafficking', and to take 'into account of the specific needs and possible multiple vulnerabilities of women drug offenders when imprisoned'.

These issues have become more prominent in UN drug policy and human rights debates – including at the CND, in the UNODC[255] and INCB[256] reports mentioned above, as well as in the International Guidelines on Human Rights and Drug Policy,[257] and reports by UNDP,[258] the OHCHR[259] and the UN Working Group on the issue of discrimination against women in law and in practice,[260] among others. The Working Group notably reported that stereotyped standards of women's 'moral' conduct plays a role in the disproportionate rates of incarceration of women for drug offences as women are judged more strictly. The Working Group concluded that 'The incarceration of women involved in low-level drug offences does not contribute effectively to addressing the world's drug problem. Instead, it perpetuates a vicious cycle of victimisation, placing them in situations of further injustice'.[261] Civil society has also been instrumental in ensuring that the issues faced by women deprived of liberty for drug offences remained high on the political agenda at national, regional and international level.[262]

> **"Drug policies cannot be effective without addressing the root causes of structural inequality and discrimination which place women in a subordinate role in society, including in the family, often leading to experiences of violence, marginalisation and domination. Marginalisation of women, poverty, gender-based violence, lack of job opportunities and absence of social protection from the State, together with the need to support their family, can drive women into committing drug-related offences."**
>
> **UN Working Group on the issue of discrimination against women in law and practice[263]**

However, repressive drug laws have consistently ignored these commitments. In most cases, women are incarcerated for drug possession for personal use, or for carrying out non-violent but highly visible drug activities, such as selling small quantities or transporting drugs, for very little financial reward.[264] Some women become involved in the illegal drug trade as a result of coercion, under the influence of their male partners and family members,[265] and many do so as a means of subsistence for themselves, their children or other dependants. Most women in prison in Latin America and Asia are single mothers responsible for several children and other dependents, with low levels of formal education and limited prospects for formal employment.[266] These intersecting vulnerabilities are compounded when women are detained and tried in a foreign country.[267]

> **"They would tell me: remember that we know where your children are, remember that we know where your family is. First we'll kill you and then your whole family."**
>
> **Liliana, coerced by an organised crime group to transport drugs from Venezuela to Argentina[268]**

The widespread use of criminal sanctions (including for women who use drugs), pretrial detention, lengthy and disproportionate prison sentences, denial of consideration of mitigating factors and lack of alternatives to incarceration for women accused of drug offences has greatly undermined the implementation of the UNGASS Outcome Document, with little progress made since 2016.[269] Research in 18 jurisdictions across the world and published in 2020 found that the complex reasons and pathways in the criminal legal system for women involved in drug offences are not adequately reflected in national legislation, sentencing practices and (where existing) sentencing guidelines.[270]

The COVID-19 pandemic has further exacerbated harms in already overcrowded and unsanitary prisons. The pandemic was an opportunity for governments to redress the situation by releasing women and other groups in situations of vulnerability – but this failed to materialise for most women incarcerated for drug offences. A study analysing prison release measures undertaken during the pandemic between March and June 2020 showed that women deprived of liberty were explicitly targeted by decongestion measures in only 20% of the countries that implemented such measures, while various countries explicitly excluded people incarcerated for drug offences from their measures. Examples of the few countries that specifically targeted women in their prison release initiatives include the UK, Rwanda and Zimbabwe, which all committed to release women imprisoned with their children – although such commitments did not always materialise in practice.[271]

Another issue covered within the UNGASS Outcome Document is the need to take into account the specific needs of women in prison. Nevertheless, as women constitute a minority of those incarcerated, prisons are generally ill-equipped to respond to their specific needs. This is particularly the case for pregnant women and women incarcerated with their children. A 2019 study found that an estimated 19,000 children lived within prisons with their mothers across the world.[272] 2020 marked the 10-year anniversary of the UN Rules for the Treatment of Women Prisoners and non-Custodial Measures for Women Offenders (the 'Bangkok Rules')[273] – specifically mentioned in the UNGASS Outcome Document – which provide recommendations for the treatment of women deprived of liberty. At the occasion of this anniversary, UN and regional human rights experts called on governments across the world to fully implement the Bangkok Rules, specifically highlighting 'harsh drug policies' as a driver for the 'excessive imprisonment of women'.[274] A 2021 civil society analysis of the past 10 years of implementation of the Bangkok Rules has also shown that drug laws and policies have systematically undermined the achievement of the recommendations included in the Bangkok Rules.[275]

> **"I served 16 years in a federal prison. I went in prison in 1998 and I came out of prison on Christmas eve 2013. During those 16 years in prison, it was horrible. I spent a year back and forth from different county jails where the food of course is horrible. The conditions, as far as the sleeping arrangements [were difficult] because you're so close to a person that if I reach my arm out I can touch that person. The officers treated us very bad, they don't respect you as a human being. And before I go in a little further, let me just say that language-wise, we try to refrain from using the word 'inmates' because that is a label that was put on us by the system to dehumanise us, and in order for us to humanise each other and our families on the inside, we cannot use that language. They are incarcerated people. They are humans as we are."**
>
> **Justine 'Taz' Moore, Director of Training, National Council for Incarcerated and Formerly Incarcerated Women and Girls, USA**

## Women in cultivation areas

There is a dearth of information regarding women involved in the cultivation of plants destined for the illegal drug market. Research and analysis conducted by civil society[276] shows that women growers of coca and opium poppy have played a critical role in sustaining and improving rural livelihoods, in caring for families, and in community organising and social movements. From their fight to assert the rights of coca-grower movements in Bolivia to their contribution to peace building in Colombia, women growers have been crucial agents of change in their communities. Women coca or poppy growers not only build knowledge and capacities in their territories, they also contribute on a daily basis to the transformation and improvement of their realities, and that of their families and villages.

> **"The income received in this work [cultivating coca or participating in its processing] has allowed us to access rights such as health, education for our children, and housing, and it has enabled our economic independence. However, and despite the responsibilities we take on in our homes and the coca fields, in the majority of cases, we do not participate on equal footing in the earnings or in the decisions about how to administer or invest the money coming from these activities."**
>
> **Final Declaration, Encuentro de Mujeres Cocaleras del Sur de Colombia**

And yet, the lives of women who grow plants destined for illegal drug markets are marked by various forms of discrimination: 'because they are women, because they are rural farmers, and because their livelihood depends on an activity that has been declared illegal'.[277] Punitive drug policies and the isolation and marginalisation caused by rural life have erected walls behind which the role of women as agents of social transformation is hidden and rendered invisible. The gender disparities in cultivation areas include reduced prospects for women in accessing public services such as education, employment outside the fields, in acquiring land titles, in wages, and in the numbers of hours women use to take care of the household, compared to men.[278] Although on paper women are now more often included as a target group in alternative livelihoods programmes, these programmes generally do little to truly address the challenges they face in their daily lives.

Here again, the COVID-19 pandemic has further exacerbated these issues. In the Rif, in Morocco, where cannabis cultivation is often the only means of subsistence for local communities, the travel restrictions imposed by the Moroccan government has meant that fewer workers are able to travel to the fields, leaving women with no choice but to work harder to ensure that cultivation runs smoothly. Trade re-

## Box 3 The case of trans women deprived of liberty

The UNGASS Outcome Document fails to recognise the specific needs and circumstances of the LGBTQ+ community.[279] This is particularly concerning given that, within the criminal legal system, LGBTQ+ people are particularly vulnerable to invisibility, discrimination and abuse. The specific situation of trans women in prison can serve as an example of how gender non-conforming people are differentially impacted by prisons and the criminal legal system.

In Latin America, civil society research[280] shows that trans women deprived of liberty face systemic psychological and physical abuse at the hands of custodial staff and other people deprived of liberty. Trans women have limited access to prevention, treatment and care for sexually transmitted infections such as HIV, syphilis, and hepatitis B, even though they reported a particularly high prevalence of these diseases. Trans women who had accessed hormones before being deprived of their liberty were denied these medicines once incarcerated. Furthermore, trans women's ability to choose in what detention facilities they will be housed in often depends on the discretion of custodial staff, resulting in most trans women in the region being incarcerated in male prisons, making them vulnerable to abuse and violence. Before coming into contact with the criminal legal system, trans women in Latin America are often confronted with hardship in accessing housing, employment, and face abuse and ill-treatment by law enforcement.

In December 2020, several NGOs signed the first-ever declaration on the rights of trans women deprived of liberty in Latin America,[281] calling for alternatives to incarceration and punishment, and the urgent need to take into account the specific needs of trans women in prison.

The stigma, discrimination, abuse and violence faced by trans women in the context of drug control is by no means limited to Latin America. A workshop held in October 2020 which gathered trans sex workers who use drugs in Pattaya, Thailand, for instance, highlighted how they faced 'widespread discrimination, violence, and oppression, especially from law enforcement'. In this context, the Health Opportunity Network[282] in Thailand helps to empower women by 'building value, pride and self-respect' through activities that aim to reduce internalised stigma for transgender people who use drugs and bringing trans women together by creating a safe space to share experiences, develop understanding of laws and protection mechanisms, and build alliances to advocate for more humane and less punitive drug policies.[283]

strictions and plummeting cannabis prices have further exacerbated the situations of vulnerability of farmers.[284] Showing a potentially promising way forward, Morocco's new medical cannabis bill states that a national agency regulating medical cannabis is to be created, with one of its duties focusing on 'advancing the status of rural illiterate working women (working in the fields)'.[285]

> **"How do women currently benefit from hemp [cannabis]? I would say nothing, just that she can get food and clothes after selling the harvest. Women do not interfere in the sale process and do çuniversity studies, learning useful healthcare provisions, those terms do not exist in the woman's dictionary in the Ketama area."**
>
> **Shadia El Brahimi, Activist for Women's Rights in Cannabis, Morocco[286]**

## 4.2 Children and young people

**Relevant UNGASS recommendations:**

- Paragraph 1.a. 'Take effective and practical primary prevention measures that protect people, in particular children and youth, from drug use initiation'.
- Paragraph 1.g. 'Develop and improve recreational facilities and provide access for children and youth to regular sports and cultural activities, with a view to promoting healthy lives and lifestyles'.
- Paragraph 4.e. '(…) ensure that the specific needs, including mental and physical needs, of underage drug offenders and children affected by drug-related crime are appropriately considered, including in criminal justice proceedings where required, including by providing those in need with drug treatment and related support services'.
- Paragraph 4.f. 'Implement age-appropriate practical measures, tailored to the specific needs of children, youth and other vulnerable members of society (…) in order to prevent their abuse of narcotic drugs and psychotropic substances, and address their involvement, use and exploitation in the illicit cultivation of crops, production and manufacturing of and trafficking in narcotic drugs, psychotropic substances and other forms of drug-related crime (….) fulfilling the obligations as States parties to the Convention on the Rights of the Child'.

In a welcome move, the 2016 UNGASS Outcome Document addresses in some detail the specific issues faced by children, teenagers and young adults in connection to drug use and drug trafficking.[287] However, the Outcome Document was not able to break away from the consolidated practice of using the protection of children and youth as a political justification for a punitive approach within the international drug control system.[288] The Outcome Document follows prior international drug documents in focusing most recommendations concerning young people on the promotion of abstinence-oriented prevention interventions.

Besides neglecting critical approaches like harm reduction and drug dependence treatment, this unbalanced framework has also contributed to invisibilise the impact of drug control on children, teenagers and young adults. Five years after UNGASS, the realisation that young people are entitled to the full enjoyment of all human rights, and not only to a narrow interpretation of the right to be protected from drugs as laid down in article 33 of the Convention on the Rights of the Child, is yet to be fully integrated in the international drug control regime (see Box 4).

### The health dimension: Prevention, treatment, and harm reduction for children and youth

In most countries, young people use more drugs, and more frequently, than older people.[289] According to UN data, for most regions and most drug types, peak levels of drug use are seen between the age of 18 and 25.[290] It is estimated that approximately 13 million people aged 15-16 used drugs in 2018, and the prevalence of cannabis use is higher amongst this group than in the whole population average.[291]

Children, teenagers and young adults use different drugs, and they use them differently than their older counterparts. Their personal circumstances, backgrounds, patterns of use and relation with figures of authority are also very different from those of older people.[292] As it befits a population that is frequently invisible in official data, it is likely that drug use amongst children and youth is underestimated and under-reported, especially for groups that are most marginalised.[293] According to the INCB Annual Report 2019, while young people of high socio-economic class are more likely to use drugs, health problems associated with drug use are more frequent amongst young people from lower class.[294]

For decades, states have approached drug use amongst children and young people with a focus on prevention, which remains the centre of gravity of the 2016 UNGASS Outcome Document. In accordance with this approach, many states have relied on 'just say no' messaging and scare tactics,[295] instead of strengthening protective factors and reducing risks. Although 'just say no' prevention in-

## Box 4 Article 33 of the Convention on the Rights of the Child

The only explicit reference to drugs in the whole body of the UN human rights conventions can be found in Article 33 of the Convention on the Rights of the Child, which commits states to 'take all appropriate measures (…), to protect children from narcotic drugs and psychotropic substances as defined in the relevant international treaties'. This provision has been frequently used by some countries to push unapologetically for drug-free policies that side-line or deprioritise alternative approaches such as harm reduction, both at home and at the UN level.[296]

However, since the 2016 UNGASS Outcome Document, the Committee on the Rights of the Child – the body of experts mandated to provide an authoritative, if non-binding, interpretation of the Convention on the Rights of the Child – has produced a large number of observations and recommendations that present a broader and more nuanced interpretation of Article 33, which includes harm reduction measures.[297] Since 2016, the Committee has recommended that Member States provide 'accessible and youth-friendly drug dependence treatment and harm reduction services' in more than 30 occasions.[298]

terventions remain widespread, scientific evidence suggests that they have had limited to no impact on drug use.[299] For instance, the second edition of the UNODC 'International standards on drug use prevention', published in 2018, notes that there is little to no evidence for the efficacy of prevention strategies based on arousing fears, lecturing, and resorting to testimonies from people who use drugs in the past,[300] although these are still widespread. Notably, the UNGASS Outcome Document encourages Member States to provide children and youth with access to 'sports and cultural activities', in order to encourage pro-social and healthy pursuits that allegedly might serve as an alternative to drug use. Many states follow this indication and promote a variety of these interventions as best practices in the international sphere.[301] Here again, however, the UNODC has found that evidence for the effectiveness of any of these actions is at best inconclusive.[302] Furthermore, a number of countries conduct mandatory drug testing in schools and other educational settings; in many cases, authorities resort to the police to administer such tests. For instance, in Sweden at least 4,000 underage people were subject to a drug test in 2019 alone.[303] In some cases, a positive test has led to suspension or expulsion from school.[304]Several studies show that drug testing in schools is an inappropriate response to drug use by students, and can constitute unlawful restrictions on the right to education, as well as a barrier to employment and other life opportunities later in life. According to the OHCHR, mandatory drug testing in educational settings may be inconsistent with the principle of the best interest of the child, and 'raises human rights concerns', including a possible arbitrary interference with the child's privacy and dignity, the violation of their bodily integrity, and, when conducted frequently, degrading treatment.[305] Mandatory drug testing efforts may also be counterproductive, with people switching to less detectable (but sometimes more harmful) substances. A large random study provided evidence that it can be detrimental to effective prevention methods based on building trust between students and teachers,[306] and the UNODC has noted that there is no evidence that drug testing is an effective prevention strategy.[307]

In addition to drug testing, in some countries it is not infrequent for the police to conduct drug searches in schools – for instance, in Belgium the number of police interventions related to drugs in schools increased more than tenfold between 2007 and 2017, the latter having seen an average of four such interventions per day.[308]

The prioritisation of these practices has side-lined other initiatives benefiting from a more solid evidence base, and to which children and youth are also entitled. Even though the Outcome Document commits states to provide health interventions 'tailored to the specific needs of children and youth' (paragraph 4.f), there continues to be a dearth of targeted, age-inclusive, youth-specific information and services, while age-based stigma and power imbalances drive away young people from services.[309] Consequently, young people are less likely to access essential harm reduction and treatment interventions, and more likely to be unaware of the risks associated with drug use, and their own rights.[310] For instance, measures such as age limits or the requirement of parental consent operate as clear barriers for young people to access NSPs, OAT, and HIV testing and counselling.[311]

## Box 5 Mobilising young people for evidence-based drug policies

While member states have focused on abstinence-based interventions for young people, other approaches with greater evidence of success, including harm reduction, have been neglected, and the voice of young people has been excluded from policy making. In response to this, various youth-led organisations have risen to fill this gap, and to advocate for a broader understanding of what it means to protect the health and human rights of children and young people within drug policies.

Youth RISE is a global network of youth-led organisations that campaigns for youth-friendly harm reduction services and health-based drug policy reform. In 2020, Youth RISE amplified the voice of young people in drug policy making processes at national and international level, in both the Global North and the Global South. For instance, Youth RISE took part in a civil society meeting on decriminalisation in Ghana, attended CND sessions, and submitted inputs to the UN Working Group on Arbitrary Detention on the intersection of drug policy and arbitrary detention.[312] The network also runs a small grants programme that supports community organisations and groups of young people affected by drug policies in every continent – including a number of COVID-19 relief grants in 2020.[313]

Other interesting examples include the Youth Organisation on Drug Action network in Europe,[314] the Paradigma Coalition,[315] or the youth-led network Students for Sensible Drug Policy (SSDP), which is comprised of dozens of chapters across the world.[316] Amongst many other campaigns, SSDP runs the peer-led education programme 'Just Say Know', which provides certification and training for young people to become peer educators and organise workshops and seminars on evidence-based drug education and harm reduction, which are often absent from schools and universities.[317]

> **"The lack of young people, and in particular young people who use drugs, in drug policy decision making bodies, is leading to a shortcoming in expertise when discussing the challenges and needs of this community. Outside of tokenistic representation, there is little engagement offered to young people and youth-led organisations when policies impacting their lives are being shaped. Young people who use drugs are experts with regards to our own situations and needs, and this lack of engagement is resulting in young people being left behind by drug policies and being left as victims of the war on drugs."**
>
> **Ailish Brennan, Executive Director of Youth RISE**

## The impact of drug law enforcement on children

In the five years since the 2016 UNGASS, children and youth have continued to be subject to the whole range of human rights violations commonly associated with the enforcement of the current drug control regime, both as targets of drug control operations themselves, and as a result of actions that target their parents and caregivers. While this is an aspect of drug policy that remains ignored and neglected – particularly at policy making level – since the 2016 UNGASS it has received growing attention from UN rights experts and civil society.

Human Rights Watch has documented that thousands of children in the Philippines have had their parents or caregivers killed since 2016, when President Duterte launched a national anti-drugs campaign. As a result, these children have suffered lasting psychological distress, and severe economic hardship. While some of them faced bullying in their school and the community, others were ultimately forced to live in the street.[318]

The disproportionate incarceration of women for drug offences has also had a dramatic impact on children. A significant proportion of women in prison for drug offences are single mothers, who are often the main caretakers of their children at the moment of detention.[319] When a parent is incarcerated, all aspects of a child's life are disrupted, from their relationship with family members and friends, to their place of living.[320] This can include traumatic separation, loss of income or difficulties at school, amongst many other consequences.[321] Other harmful aspects of detaining a mother include the permanent separation of children from mothers who are housed in prisons far away from their primary residence, and the fact that an estimated 19,000 young children worldwide live within prison with

their mothers,[322] in environments that are clearly unfit to meet their specific needs.

Children are also impacted by welfare systems that punish parents who use drugs. Some studies estimate that over 80% of all foster system cases in the USA involve allegations of caretaker drug use at some point in the life of the case.[323] Although there is insufficient evidence of a causal link between drug use and child maltreatment, many US agencies and family courts have equated drug use with risk of child harm, in some cases separating children from their parents and primary caregivers.[324]

In its 2018 report to the Human Rights Council, the OHCHR stated that the consequences of a criminal record for a drug-related offence for a young person include discrimination, stigmatisation, and reduced prospects for access to higher education and employment. Children of parents incarcerated for a drug-related offence may also suffer harm and face stigma. The best interests of the child should be taken into account when a parent is charged with a drug-related offence, and non-custodial measures should be considered.

> **"I had to give up all my plans in order to focus on taking care of my sisters. In fact I left school, I left my friends, I gave up on living the life of a teenager in order to focus on the life of a mother… I left school when I was about fifteen, and I started to take on several jobs, such as cleaning houses, taking care of children, whatever would help."**
>
> **Ana, who is from Mexico and was 20 at the time of the interview, talking about the impact of her mother's incarceration[325]**

## 4.3 Criminal legal reform

**Relevant UNGASS recommendations:**

- Paragraph 4.j. Encourage the development, adoption and implementation (…) of alternative or additional measures with regard to conviction or punishment in cases of an appropriate nature, in accordance with the three international drug control conventions and taking into account, as appropriate, relevant United Nations standards and rules, such as the United Nations Standard Minimum Rules for Noncustodial Measures (the Tokyo Rules).
- Paragraph 4.l. 'Promote proportionate national sentencing policies, practices and guidelines for drug-related offences whereby the severity of penalties is proportionate to the gravity of offences and whereby both mitigating and aggravating factors are taken into account'.
- Paragraph 4.m. 'Implement, where appropriate, measures aimed at addressing and eliminating prison overcrowding and violence'.
- Paragraph 4.o. 'Promote and implement effective criminal justice responses to drug-related crimes to bring perpetrators to justice that ensure legal guarantees and due process safeguards pertaining to criminal justice proceedings, including practical measures to uphold the prohibition of arbitrary arrest and detention and of torture and other cruel, inhuman or degrading treatment or punishment and to eliminate impunity, in accordance with relevant and applicable international law and taking into account United Nations standards and norms on crime prevention and criminal justice, and ensure timely access to legal aid and the right to a fair trial'.

### Addressing the over-incarceration of people for drug offences

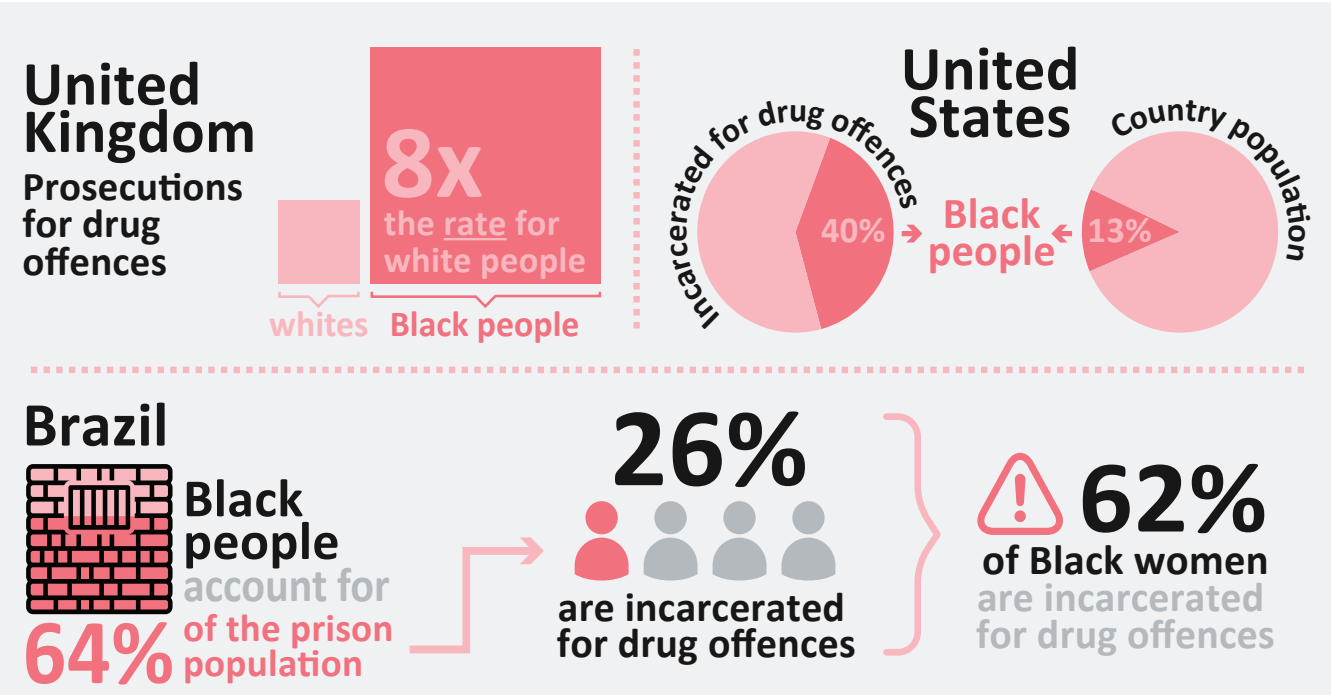
In paragraph 4(m) of the UNGASS Outcome Document, member states committed to implement 'measures aimed at addressing and eliminating prison overcrowding and violence', mentioning specifically the Nelson Mandela Rules and the Bangkok Rules (see above).

In March 2019, the UN system coordination Task Team reported that one in five people in prison are incarcerated for drug offences.[326] As mentioned above, this proportion is significantly higher for women.

The over-incarceration of people for drug offences has largely contributed to prison overcrowding, including through the use of mandatory or systematic pretrial detention, delays in court decisions, limited access to legal aid, disproportionate sentencing, and lack of access to meaningful alternatives to incarceration. In 2018, the OHCHR reported that 'United Nations human rights mechanisms have expressed concern about the unnecessary and disproportionate use of the criminal justice system for drug-related offences' and 'over violence in prisons associated with prison congestion'.[327]

Even more problematically, drug law enforcement and criminal sanctions have disproportionately affected people belonging to racial or ethnic minorities, despite similar rates of drug use. In the UK, it is estimated that black people were prosecuted for drug offences at more than eight times the rate of white people in 2017, and were sentenced to immediate custody nine times the rate of white people. Furthermore, Black and Asian people were convicted of cannabis possession at 11.8 and 2.4 times the rate of white people, despite lower rates of self-reported cannabis use.[328] A 2018 study from the USA reported that although black people comprise 13% of the US population and use drugs at similar rates to people of other races, they comprise 29% of those arrested for drug offences and represent nearly 40% of those incarcerated in state or federal prison for drug law violations.[329] In 2017, 64% of all people incarcerated in Brazilian prisons were black; 26% were in prison for a drug offence – a percentage that rises to 62% for black women.[330] Research shows that most of them were unarmed and possessed small amounts of drugs at the moment of their detention.[331]

In recognition of the need to reduce prison overcrowding and its associated harms, the UNGASS Outcome Document promotes both proportionate sentencing for drug offences (paragraph 4.l) and alternatives to conviction or punishment (paragraph 4.j).




> "Important recent analyses demonstrate that the war on drugs has operated more effectively as a system of racial control than as a mechanism for combating the use and trafficking of narcotics."

**UN Working Group of Experts on People of African Descent**[332]

The need for both initiatives has become particularly urgent in the context of COVID-19. Indeed, people deprived of their liberty are particularly vulnerable to contracting COVID-19, especially those incarcerated in overcrowded prisons, where it is difficult to maintain physical distancing and/or provide basic levels of sanitation, hygiene and medical care. By March 2021, at least 527,000 people in prison had contracted COVID-19 across 121 countries, with over 3,800 recorded deaths across 47 countries – although these numbers are likely to be much higher considering the lack of transparency in prisons data and limited testing among people deprived of liberty.[333] As a result, various UN agencies have urged governments worldwide to urgently reduce their prison population in an effort to prevent further outbreaks.[334] The UNODC, for instance, has called for the immediate consideration of alternatives to incarceration – including alternatives to pretrial detention and the commutation or temporary suspension of certain sentences.[335]

> "We urge political leaders to consider limiting the deprivation of liberty, including pretrial detention, to a measure of last resort, particularly in the case of overcrowding, and to enhance efforts to resort to non-custodial measures. These efforts should encompass release mechanisms for people at particular risk of COVID-19, such as older people and people with pre-existing health conditions, as well as other people who could be released without compromising public safety, such as those sentenced for minor, non-violent offences, with specific consideration given to women and children."

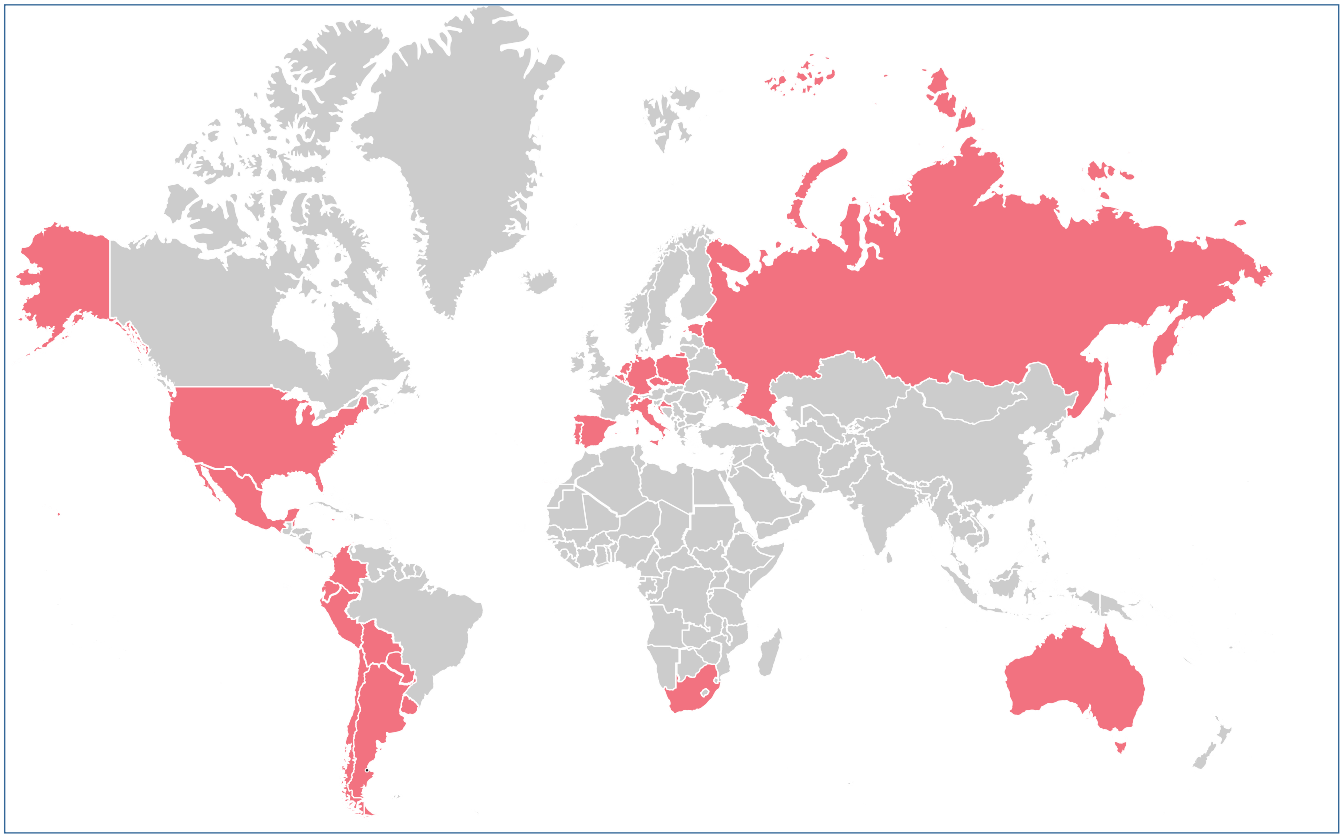
**UNODC, WHO, UNAIDS and OHCHR joint statement on COVID-19 in prisons and other closed settings**[336]

In response to the pandemic, at least 109 countries and territories adopted decongestion measures between March and June 2020, including early releases (54 countries), pardons (34 countries), diversion to home arrest (16 countries) and release on bail/parole (8 countries). However, even at this time of crisis, these measures only resulted in the release of around 639,000 prisoners, representing a mere 5.8% of the global prison population.[337] Furthermore, at least 28 countries (that is, one in four) explicitly excluded people detained for (at least some) drug offences from their decongestion measures.[338]

> "At the start of the COVID crisis, thanks to our advocacy actions with the authorities, we were able to release a large number of detainees and more specifically drug users who committed non-violent offenses in Mali. it's a victory that COVID has allowed us".

**Jérôme Evanno, Paroles Autour de la Santé, Côte d'Ivoire & Mali**

**Figure 3.** Countries and jurisdictions having decriminalised drug use and drug possession for personal use



## Ensuring more proportionate penalties for drug offences

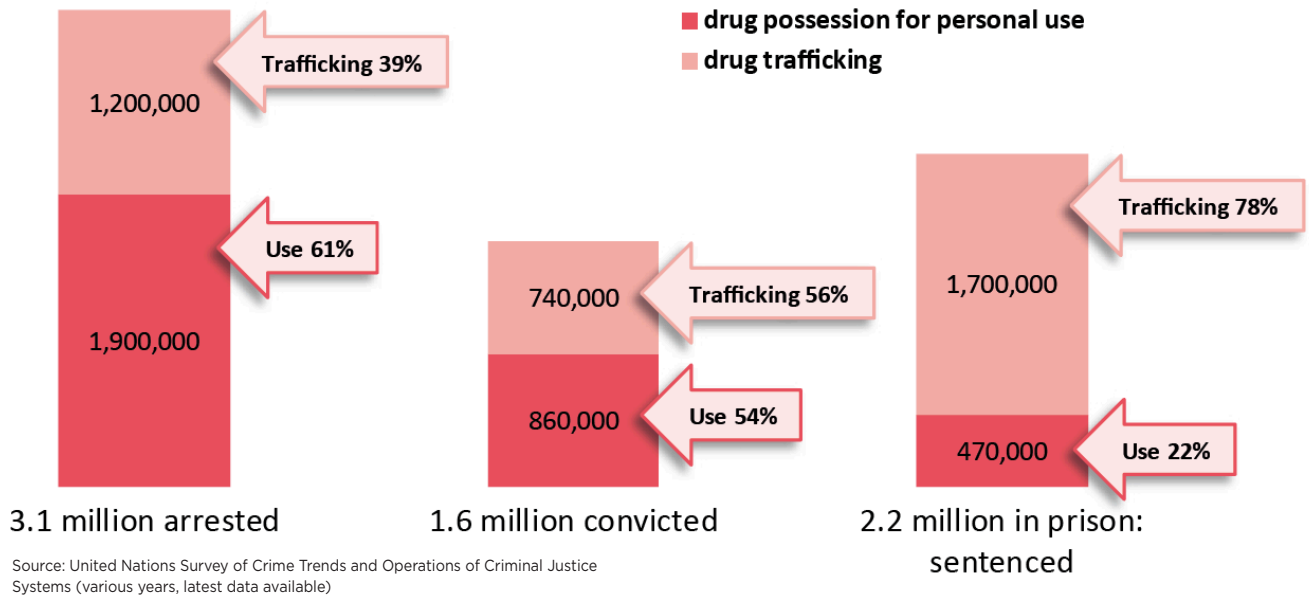
Prison decongestion measures will only be effective at reducing overcrowding in the long term if they are accompanied by meaningful reforms to ensure more proportionate penalties, or the removal of such penalties, for drug offences – thereby reducing the influx of people coming into prisons. The OHCHR in particular has recommended that minimum sentences for drug offences should be repealed and replaced by sentencing guidelines that are proportionate and give sufficient flexibility to judges regarding sentencing decisions.[339]

However, only limited progress has been made in this regard since 2016. There have been some notable exceptions of policy and legislative reforms, but these have generally been limited both in scope and impact. In Tunisia, for instance, an amendment to Law 52 was adopted in 2017 to grant judges powers of discretion and take into account mitigating circumstances when imposing a prison sentence for first-time offenders caught in drug possession for personal use, instead of the one-year minimum sentence applied prior to the reform.[340] However, this is a far cry from ensuring the full decriminalisation of drug use and possession and most people who use drugs continue to be imposed a prison sentence.[341] Another example is Belarus, where a 2019 review of the country's Criminal Code reduced the lower limit of punishment for drug distribution by two years.[342] In Thailand, a 2017 amendment to the drug legislation reduced the length of sentences for drug offences to ensure more proportionate sentencing, although the revised penalties remain high overall, as is the number of people being incarcerated for drug offences.[343] The most recent sentencing reform took place in England and Wales in 2021, where the Sentencing guidelines for drug offences were revised, partly to reflect the disparity in sentencing outcomes associated with ethnicity and gender.[344]

## Ending the overreliance on pretrial detention

The widespread use of pretrial detention is a major contributing factor for overcrowding in detention facilities, despite the fact that it should always be the exception rather than the rule. Excessive reliance on pretrial detention can result in stigmatisation and loss of income leading to the breakdown of family structures. This can have devastating consequences in societies where many live in situations of poverty and depend on familial ties to survive. Indeed, one of the indicators used to measure progress against Sustainable Development Goal 16 ('peace, justice and strong institutions') is the proportion of pretrial detainees in prison populations. Nonetheless, around three million people are currently held in pretrial detention globally – a significant proportion of whom for drug offences.[345]

**Figure 4.** Latest estimates of the number of people in the criminal legal system for drug offences




Source: United Nations Survey of Crime Trends and Operations of Criminal Justice Systems (various years, latest data available)

Taken from: UNODC World Drug Report 2020

## Decriminalising drug use and possession

Paragraph 4.j of the UNGASS Outcome Document encourages the 'development, adoption and implementation… of alternative or additional measures with regard to conviction or punishment in cases of an appropriate nature'. The push for decriminalising drug use and possession for personal use is unequivocally supported by the 'United Nations System Common Position supporting the implementation of the international drug control policy through effective inter-agency collaboration' (commonly known as the 'UN System Common Position on drug-related matters') – in which all UN agencies agreed to promote 'alternatives to conviction and punishment in appropriate cases, including the decriminalization of drug possession for personal use'.[346]

It is important to note here that the INCB has concluded that 'The treaties do not require the incarceration of drug users, but rather provide for alternatives to conviction or punishment for those affected by drug abuse…That some countries have chosen incarceration rather than treatment has been a denial by governments of the flexibility that the treaties provide'.[347]

The Committee on Economic, Social and Cultural Rights has established that the criminalisation of drug use can be an impediment to the realisation of the right to health,[348] while the UN Working Group on Arbitrary Detention has found that 'drug consumption or dependence is not a sufficient justification for detention'.[349] The High Commissioner for Human Rights also found that the criminalisation of drug use deters people from accessing treatment and other health and social services. Together with the stigmatising attitudes and discrimination it fuels, criminalisation also contributes to risky practices and higher risks of overdoses due to the need to use drugs quickly and in unsafe conditions.[350] The UNAIDS Global AIDS Strategy for 2021-2026 reaches similar conclusions and includes, as a priority action, the need to 'Create an enabling legal environment by removing punitive and discriminatory laws and policies, including laws that criminalize… drug use or possession for personal use'.[351]

> "It's high time we replace punishment with help."
>
> Norwegian Health Minister Bent Hoie[352]

Some progress has been made towards the decriminalisation of drug use and possession for personal use since 2016, with Antigua and Barbuda (in 2018), Belize (in 2017), Ghana (2020),[353] South Africa (in 2018) and various US states (2016-2020) having decriminalised the use and possession of certain drugs, mostly cannabis. This brings the number of countries having adopted a decriminalisation model to 28, or over 50 jurisdictions – with ongoing debates and reforms underway in additional countries including Iceland, Malaysia and Norway. It should be noted, however, that there are significant differences and levels of effectiveness between these decriminalisation models.[354]

Although more countries and jurisdictions are moving towards decriminalisation, much more needs to be done in this regard, as 85% of countries worldwide continue to criminalise the possession of drugs for personal use. According to the World Drug Report

## Box 6 The silence of the UNGASS: The case of the death penalty for drug offences


One of the main criticisms[355] against the UNGASS Outcome Document was the absence of any condemnation of the death penalty for drug offences. While dozens of member states made statements in favour of abolition at the UNGASS itself,[356] the text contains no language on a punishment that is contrary to international human rights law.

Under the International Covenant on Civil and Political Rights, which has been signed and ratified by 167 states,[357] capital punishment can only be imposed for the 'most serious crimes'.[358] A large array of UN bodies, from the Economic and Social Council[359] to the Human Rights Council[360] and the Human Rights Committee,[361] have stated that the term 'most serious crimes' must be interpreted as the intentional deprivation of life, and have concluded that no person can be lawfully sentenced to death for a drug offence. In recent years, the INCB has also encouraged all States that retain the death penalty for drug-related offences to commute death sentences that have already been handed down, and to consider the abolition of the death penalty for drug offences.[362]

The imposition of the death penalty for drug offences is widespread, though the number of executions has decreased significantly in the past few years. The same year the UNGASS Outcome Document was adopted, however, at least 369 people were executed for a drug offence, while thousands languished on death row.[363] These figures may be much higher as they exclude data from China, as these are not available for the public. In comparison to that, in 2020 at least 29 people were executed, while over 3,000 people remained on death row for a drug offence – in many cases for several years.[364] The decrease in the number of those executed in the last years is largely due to legal reforms in Iran,[365] and more recently to a *de facto* moratorium on executions for drug offences in Saudi Arabia.[366] In 2017, Malaysia also moved to exclude drug trafficking from the list of offences for which the death penalty is mandatory, though capital punishment is still possible.[367]

Just as it is the case for the other punishments associated with drug control, available data shows that the main victims of the death penalty for drug offences are people involved in the lower ranks of the illegal drug markets, such as those who transport drugs.[368] People who have been marginalised and oppressed are disproportionately more likely to be sentenced to death, including women, foreign nationals, and people discriminated against on the basis of race and ethnicity.[369] For instance, in the Middle East and Asia, drug offences are the second largest category of crimes leading to death sentences for women.[370] Lastly, the death penalty is frequently marred by serious violations of due process rights, from the violation of the prohibition of coerced confessions to the right to legal aid.[371]

2020, 3.1 million people worldwide were arrested for drug offences, 61% of whom for drug use activities. Of the 2.5 million people sentenced to prison for drug offences, 22% were incarcerated for drug use offences (see Figure 3). This proportion may be significantly higher, however, as many countries do not differentiate between possession for personal use and possession for supply purposes. Cannabis remains the drug that brings most people into contact with the criminal legal system, accounting for more than half of all drug offence cases based on reports from 69 countries over the period 2014 to 2018.[372] This is despite the fact that the threat of incarceration has no deterrent effect for drug use and undermines access to essential health services.[373]

> "Identifying as a person who uses drugs means you break the law... You can't rely on the system for anything. In other words, you can't get healthcare. The criminal justice system sees you as a criminal, so if you go and report a crime, you get laughed

**at, you get looked like 'What do you mean you got robbed? Aren't you the one who does the robbing since you use drugs?'.**

**Nelson Medeiros, South African Network of People who Use Drugs[374]**

## Promoting alternatives to incarceration

Beyond decriminalisation, many countries use some form of alternative to incarceration, and various regional bodies have promoted them as a key component of their drug strategies since 2016 – including the EU[375] and the African Union.[376] However, when these alternatives do exist, their use may be denied to people convicted of drug offences. The 2020 study on sentencing practices for women mentioned above shows that while non-custodial sentences are the most common form of sentence for low-level drug offences committed by women in some countries such as England and Wales, Germany and New Zealand, in Russia non-custodial sentences are only issued for about 4% of women convicted of drug offences.[377]

In addition, the nature and scope of these alternatives are not always consistent or aligned with human rights principles. Drug courts, for instance, have been promoted principally in the USA, Latin America and the Caribbean, but now also in Africa and Asia, as an alternative to incarceration for drug offenders – but have been widely criticised. They have, in most cases, proven to be costly, with limited impacts on levels of incarceration (as those failing to remain abstinent may be imposed a harsher penalty than if they had not participated in the programme, and they have no right of appeal as they are obligated to plead guilty in order to enter the programme), and denying the provision of a wide enough range of evidence-based treatment options (with many programmes refusing to offer OAT).[378] In 2019, the Special Rapporteur on the independence of judges and lawyers and the Special Rapporteur on the right to health criticised drug courts for their potential to infringe on 'patient confidentiality and autonomy, loyalty, privacy and the ability of the patient to give meaningful consent to treatment'. The experts explained that 'these courts usually blur the line between voluntary and coerced treatment', while 'implementing drug courts without investing in proper treatment means that a system of abuse is legitimized through its use by the courts'. The experts concluded that 'The propensity for human rights violations in the context of drug courts is such that States should take cautions against the continued roll-out of drug courts in countries where oversight and monitoring mechanisms are absent'.[379]

Other alternatives, such as the Law Enforcement Assisted Diversion (LEAD) programme now expanded to various US cities,[380] or the 'SUTIK' programme in Estonia (launched in 2017),[381] have proven to be more effective at meeting people where they are and providing them with non-judgemental care and support.

**"I love Singapore. Everything I love is here. Being Singaporean tough, has expedited my execution. I dream for better days because hope is my only possession."**

**Syed Suhail bin Syed Zin, who is in the death row in Singapore for possessing 38.84 grams of heroin. Although all ordinary appeals have been exhausted, on 17 September 2020, the High Court of Singapore granted Syed an interim stay of execution pending further hearings in court[382]**

**"The [Philippines'] Commission on Human Rights is resolutely opposed of the death penalty and its reimposition. We are strongly advocating against the death penalty bills tabled in Congress, and we have released advisories and research studies advising government of its treaty obligations. We presented empirical data and evidenced-based findings of capital punishment not having a place in the justice system."**

**Karen Gomez-Dumpit, member of the Philippines' Commission on Human Rights, in a statement on the 2020 United Nations General Assembly Resolution on Moratorium on the Use of the Death Penalty[383]**

## The right to a fair trial

In paragraph 4.o of the Outcome Document, Member States undertook to ensure that criminal legal responses to illegal drug activities comply with 'legal guarantees and due process safeguards', including the prohibition of 'arbitrary arrest and detention, and of torture and other cruel, inhuman and degrading treatment'. These commitments are in line with the most basic obligations of states under the UN human rights regime. However, five years later, the quantity and seriousness of human rights violations associated with criminal legal responses to drugs continue to be overwhelming, including for people on death row (see Box 6).[384]

The right to a fair trial is complex, combining different procedural safeguards.[385] Access to effective legal counsel is a crucial element within this

framework, as it enables those undergoing criminal proceedings to understand, and participate in a meaningful way in, a process that conditions their life in extreme ways, and to enjoy the rights to which they are legally entitled.[386] Under the 'United Nations Principles and Guidelines on Access to Legal Aid in Criminal Justice Systems',[387] the provision of legal aid to those who cannot afford or obtain counsel is essential for the functioning of a criminal legal system, and states should consider it 'their duty and responsibility'.[388] The lawyer provided should have the experience and competence commensurate with the nature of the offence[389] – a requirement that is particularly important for drug-related proceedings, given the disproportionately high penalties envisaged in many legislations.

Access to legal counsel is also indispensable for the effective implementation of legal measures that are critical to reducing the number of people incarcerated for drug offences, such as alternatives to incarceration and punishment before and after sentencing.[390] For example, even in jurisdictions where pretrial detention is not mandatory under the law, research has shown that socio-economic factors such as poverty, low social status, gender and race play an important role in determining whether a person is imprisoned on remand, while that the inadequate provision of legal aid exacerbates the inequalities within the legal system.[391]

A study on the detention of women for drug offences in Latin America shows that the rate of women in pretrial detention for drug activities is higher than that of men across the region, in some cases by a very significant margin (52% compared to 18% in Argentina in 2017, and 45% compared to 20% in Colombia in 2019, amongst many other examples);[392] lack of access to legal counsel is frequently cited among the reasons for this trend. Another concerning example is the Philippines, which has one of the lengthiest pretrial detention processes in the world,[393] and where lawyers charged with providing legal aid are underfunded and overstretched, with each of them handling an average of 504 cases in court in 2017.[394] Recent qualitative research shows how, without adequate legal counsel, people charged with a drug offence in Cambodia are not even aware that they could request being freed from pretrial detention.[395]

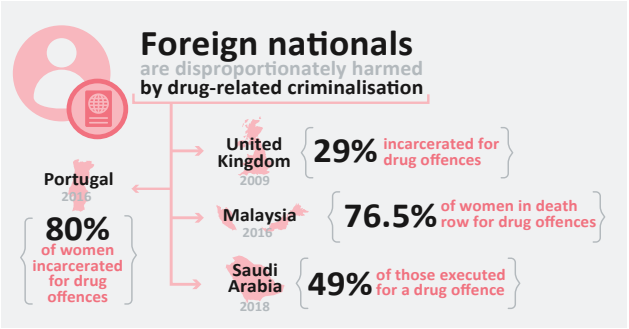
Another central element of the right to a fair trial is the right to be presumed innocent until proven guilty, which is established in Article 14 of the International Covenant on Civil and Political Rights. The OHCHR has noted that, under some legal systems, a person caught in possession of a certain amount of drugs, or in possession of the keys to a building or vehicle where such amounts are found, is presumed to be guilty of possessing these drugs for the purpose of trafficking.[396] This practice is particularly troubling in countries where such presumption can lead to the imposition of the death penalty, as it is the case in Singapore[397] and in Malaysia.[398]

## Marginalised people in the criminal legal system

Even though the UNGASS Outcome Document singles out 'vulnerable members of society' amongst the populations for whom rights protections should be specially upheld (paragraph 1.a), marginalised and oppressed people continue to suffer from a wide range of rights violations when they are involved with the criminal legal system due to drug-related activities.

In the last five years, UN entities and civil society have documented how the enjoyment of the their right to a fair trial is often restricted on the basis of race, ethnicity,[399] gender identity, or sexual orientation.[400] In a survey of practitioners published in 2019, lawyers from different countries pointed to race as 'a factor capable of causing injustice at the pretrial stage', thus limiting access to bail, in some cases because of prejudice.[401] In Mexico, approximately 8,000 indigenous people are detained on remand – some of them for years.[402] The reasons given for this situation include lack of public defenders, insufficient access to legal aid, and absence of interpreters that can translate the proceedings from Spanish into the language of the person undergoing trial.[403] A 2020 review of the situation of trans women deprived of liberty in Latin America found a connection between the incarceration of trans women and punitive drugs law, despite the general dearth of information on this population,[404] which adds to the OHCHR finding that LGBTQ+ people are disproportionately impacted by drug policies.[405]

Across the world, a disproportionate number of people incarcerated for drug offences are detained abroad – and their fair trial rights are seriously compromised. According to research published in 2016,




in Portugal 80% of foreign women in prison had been convicted for a drug offence.[406] In Malaysia, 85% of all women on death row are foreign nationals, and 90% of them were convicted for drug activities.[407] Tragically, a significant number of those executed for drug offences in 2018 were not nationals to the county where they were killed – for instance, half of the people executed for a drug offence in Saudi Arabia that year.[408] In a visit to Pakistan in February 2019, Saudi Crown Prince Mohammed Bin Salman announced the repatriation of approximately 2,000 Pakistani prisoners held in Saudi Arabia,[409] but the implementation of this measure has been significantly delayed.[410]

Lack of effective legal counsel is only one of the many issues undermining the right to a fair trial of foreign nationals charged with a drug offence. These include insecure migration status; a lack of knowledge or understanding of the laws, judicial system or language of the country in which they are being held; limited financial means to secure legal counsel or post bail; and no stable housing or job, which may disqualify them from alternatives to incarceration.[411] Even when they are eligible for bail, foreign nationals are more likely to be imposed pretrial detention, in part due to fear of flight,[412] but also because in many cases they are not provided with legal aid and translation upon detention. When a foreign person is detained, the Vienna Convention on Consular Relations requires local authorities to inform the consular services of the relevant home country, so that they can provide assistance, legal counsel and interpretation. However, such assistance is often not provided on time.[413]

## Widespread impunity for serious rights violations

With their voice and rights severely restricted within the sphere of the judicial system, many of the survivors of rights violations committed in the name of drug control are denied access to effective remedy, which requires reparation and compensation.[414] While the 2016 UNGASS Outcome Document committed states to 'eliminate impunity' (paragraph 4.o), a particularly shocking example of this has emerged since 2016: the lack of accountability for the thousands of killings committed in the context of the Philippines' national anti-drugs campaign.

Since Rodrigo Duterte took power as President of the Philippines in mid-2016, official figures[415] indicate that at least 8,336 people have been extrajudicially killed in drug control operations, while civil society has recorded over 25,000.[416] President Duterte has repeatedly encouraged these killings. In June 2020, the OHCHR found that there had been 'near impunity' for these violations, and there had been only one conviction for a killing committed during a drug control operation.[417]

In response to this situation, UN human rights experts[418] and civil society[419] have repeatedly urged the Human Rights Council to establish an independent and impartial international investigation on these abuses, but so far the Council has refused to follow this path, instead opting for capacity building and technical assistance to the Philippines.[420] This stands in stark contrast with the December 2020 finding by the Prosecutor of the International Criminal Court that there is a 'reasonable basis' to believe that President Duterte's war on drugs could constitute a crime against humanity.[421]

## Prohibition of arbitrary arrest and detention, and of torture and other cruel, inhuman or degrading treatment or punishment

Paragraph 4.o of the UNGASS Outcome Document promotes 'practical measures to uphold the prohibition of arbitrary arrest and detention and of torture and other cruel, inhuman or degrading treatment or punishment'. Under international human rights law, a detention is arbitrary when it includes 'elements of inappropriateness, injustice, lack of predictability and due process of law, as well as elements of [un] reasonableness, [lack of] necessity and [lack of] proportionality'.[422] Similarly, the UN Working Group on Arbitrary Detention has found that a detention, even if authorised by law, may still be considered arbitrary if 'based on arbitrary legislation or it is inherently unjust',[423] while the International Guidelines on Human Rights and Drug Policy have concluded that drug use and dependence do not constitute a sufficient basis for detention.[424]

A significant part of this report lists different forms of arbitrary detention. That is certainly the case for the administrative detention of people who use drugs in CCDCs, as already established by the UN Working Group on Arbitrary Detention in 2015,[425]

but also for most forms of involuntary internment in private 'drug-rehabilitation' centres, and for the thousands of arrests of people who use drugs taking place every day in jurisdictions where drug use and possession for personal use is criminalised. In a welcome move, the UN Committee on the Rights of People with Disabilities has increasingly provided recommendations against involuntary interment and treatment of people with a drug dependence under health legislation.[426]

At the beginning of the 2010s, various Asian countries announced plans to redirect resources from CDDCs to voluntary treatment,[427] but in practice the region has followed an opposite path. For instance, Vietnam has actually increased the number of detainees in administrative detention, from roughly 30,000 in 2012, to approximately 50,000 in 2017.[428] Similarly, while in 2010 Malaysia began to replace CDDCs with voluntary treatment, by the end of 2017 approximately 5,000 people were still detained in Malaysian CDDCs – the same as in 2012.[429] In all of these cases, detention is arbitrary because it constitutes an inappropriate response to drug use, it is inherently disproportionate, and it can lead to abuse and ill-treatment.[430] In many cases, it is also implemented in a discriminatory way, targeting people most oppressed and marginalised.

Despite being prohibited in all circumstances, torture and other forms of cruel, inhuman or degrading treatment and punishment have also been documented in other sections of this report – particularly in our chapter on treatment, with little to no progress made since 2016. A broad range of abuses, including discipline-based drug 'treatment', forced labour, humiliation and the denial of food or medication, are frequently reported in prisons, CCDCs, and in certain private 'drug-rehabilitation' centres.

In some Asian, African and Middle Eastern countries, courts and administrative bodies may impose corporal punishment for a number of drug offences (such as in Brunei Darussalam, Indonesia, Iran, Malaysia, the Maldives, Nigeria, Saudi Arabia, Singapore, the United Arab Emirates and Yemen), including on children.[431]

Physical violence and brutality often underpin interactions between law enforcement and people involved in illegal drug activities, including people who use drugs, with alarming reports of beatings, coercion, or sexual abuse in countries as diverse as Mexico, Indonesia, Russia and Zimbabwe.[432]

Lastly, the UN Committee Against Torture has found that the denial of OAT for people deprived of liberty experiencing withdrawal symptoms can constitute in itself a form of ill-treatment, especially when it is deployed as an instrument for eliciting confessions.[433]

## 4.4 Indigenous and cultural rights

**Relevant UNGASS recommendations:**

- Ensure the protection of human rights in cultivation areas, including traditional licit uses (paragraph 4.i)

Paragraph 4.i is the only recommendation within the UNGASS Outcome Document which refers to indigenous rights, particularly citing the UN Declaration on the Rights of Indigenous Peoples (UNDRIP).[434] The recommendation itself is worded nearly identically to Article 14.2 of the 1988 UN Convention Against Illicit Traffic in Narcotic Drugs and Psychotropic Substances,[435] which serves as the only human rights provision within the three UN drug control conventions. This provision more specifically calls on signatory states to respect fundamental human rights in conducting 'measures to prevent the illicit cultivation and to eradicate plants containing narcotic and psychotropic substances'. In this regard, such measures should 'take due account of traditional licit uses, where there is historical evidence of such use, and of the protection of the environment'.

As elaborated above, the incorporation of human rights obligations and principles in supply-side drug policies has mainly been limited to high-level international discussions, for instance in the International Guidelines on Human Rights and Drug Policy. In practice, however, supply-side policies continue to result in human rights violations. Forced eradication, which has continued to occur in the past five years, violates people's and communities' basic human rights, notably but not limited to[436] the right 'to live a life in dignity and to be free from hunger, as well as their right to an adequate standard of living'.[437] These human rights violations also affect indigenous communities, for whom psychoactive substances such as coca, cannabis, and opium not only provide them with livelihoods, but also hold important spiritual, medicinal, and cultural value.[438]

Indigenous communities 'are also victims of the drug producers who remove them from their lands or forcibly recruit them into the production process'[439] for example as recently experienced by the Indigenous Cacataibo communities in Peru.[440] This vicious cycle – of exploitation in the illegal drug trade as well as repression via drug control measures and the expansion of extractive industries – also has a destructive impact on the environment and the various kinds of natural resources which indigenous communities depend on.

> **"In our ancestors' time, there were walnut trees, fig trees, cherry trees, vines, everything all together, and the local kif [Morocco's traditional cannabis] was planted in small plots so that it didn't take over the place, our ancestors chose specific plots, the most fertile, land that was well prepared, it had to be flat..."**
>
> **Reports from farmers in the Rif region of Morocco[441]**

The UNGASS Outcome Document's reference to the UNDRIP marks a positive sign to bridge the gap between the UN drug control system and the UN human rights framework. The UNDRIP calls for the fulfilment of various rights of indigenous peoples, covering issues such as self-determination, autonomy, participation, consultation and consent, use of territories and resources, and cultural integrity.[442] In line with this, the International Guidelines of Human Rights and Drug Policy further emphasise that indigenous peoples also have the right to 'enjoy culture and to profess and practise religion', and to continue their spiritual, traditional, medicinal, and other customary uses (and cultivation) of psychoactive plants, including those controlled by drug legislations.[443] Though constituting a positive shift in discourse at the international level,[444] this provision regarding traditional uses of controlled substances remains detached from reality, and traditional uses of substances like coca, cannabis, and opium among indigenous communities are still regarded as a form of violation of drug laws.

The impacts of drug control become even more severe when indigenous communities are involved

## Box 7 Protecting the right to personal autonomy and self-determination for people who use drugs in Mexico and South Africa

Since the adoption of the UNGASS Outcome Document, two countries have made progress in recognising the right to personal autonomy and self-determination, which are worth highlighting.

In October 2018, the Supreme Court of Mexico declared the absolute prohibition of cannabis to be unconstitutional, establishing a jurisprudence which crucially paved the way for legislative changes related to cannabis use, possession, and cultivation intended for non-commercial or personal use. Among other provisions, the Supreme Court recognises that the State shall protect 'the free development of personality and personal autonomy as inalienable rights of adults', which includes the right to cultivate and consume cannabis for personal use.

A similar decision was reached in South Africa in September 2018, calling on the decriminalisation of people for drug use and possession for personal use. These court decisions are important for their recognition of 'the concept of dignity, including the right to privacy, self-determination, and the right to the free development of personality'. IDPC's 'Principles for the legal regulation of cannabis', published in 2020, concluded that 'State interference should… find a balance between establishing the least restrictive limits possible for individual autonomy, and prevent possible intrusions outside of that individual sphere'.[445]

## Box 8 Advocating for the cultural rights of Andean migrants in Europe

In the past years, various courts in Spain and other European countries have prosecuted migrants caught in possession of coca, many of whom come from the Andean region such as Bolivia and Peru, where the coca leaf has long been used for social, spiritual and healing purposes. In support of those prosecuted, organisations such as Fundación ICEERS and the Transnational Institute (TNI) developed and applied a legal defence strategy focusing on the cultural rights of these migrants to consume and possess coca, as well as the relatively low public health risk brought about by such use and possession.

For example, a Bolivian citizen in Spain was caught in possession of 4.5 kilograms of coca for chewing and brewing tea. The public prosecutor, linking such a possession of leaves with the illegal cocaine market, called for a four-year prison sentence and a fine of EUR 2,000, as well as a possible deportation. Following a defence strategy by ICEERS and TNI, the Bolivian citizen ended up with a six-month prison sentence and a fine of EUR 30. The outcome was still far from ideal, but as asserted by advocates working on this case, 'in Spain, a sentence of less than two years does not result in actual jail time, but the person in question is left with a criminal record'. This case represents only one of the many cases involving migrants in Europe, some of whom have been acquitted thanks to the aforementioned legal defence strategy.[446]

In this context, advocates vitally acknowledge that 'the connection of coca to the cocaine market, and its traditional meaning in places where the plant is not native, are some of the most challenging issues for the current international drug control system'.[447]

in the illegal cultivation of crops necessary for their survival, in some cases because their prior livelihoods and ways of living were undermined and/or made no longer possible due to the increasing presence of extractive industries and land grabs.[448] These trends have sometimes led indigenous farmers to cultivate their crops on communal or public lands, for instance in Latin American countries such as Colombia, meaning that they do not have access to official land titles,[449] and therefore are often barred from accessing public services and/or financial assistance. Meanwhile, indigenous communities around the world are losing their right to collectively manage the land and resources according to their traditional customs,[450] while they continue to be left out of policy making spaces and processes which affect their lives. These tendencies – which contravene the principles of consent and meaningful participation as outlined

in the UNDRIP as well as in the UN Declaration on the Rights of Peasants and Other People Working in Rural Areas[451] – are unfortunately still common in drug policy making processes.[452]

Lastly, in the context of human rights issues in illegal cultivation areas, it is important to note the role, as well as the often neglected cultural and traditional rights of communities who are not traditionally categorised as indigenous peoples. These include, but are not limited to, certain communities in the Caribbean, such as the Rastafari and Maroon communities in Jamaica. Prior to the UNGASS, in 2015, the Jamaican government announced a formal recognition of the sacramental use of cannabis by the Rastafari community. However, such a recognition remains to be done for Maroon communities, for whom cannabis holds equally important traditional and historical value.[453]

# Notes

# Part 5

## Ensuring the meaningful participation of civil society, especially affected communities

# 5.1 Civil society and community engagement in global drug policy debates

**Relevant UNGASS recommendations:**

- Paragraph 1.q. 'Intensify, as appropriate, the meaningful participation of and support and training for civil society organizations and entities involved in drug-related health and social treatment services'.
- Paragraph 4.a. 'Enhance the knowledge of policy-maker (…) and to that end encourage cooperation with and among the UNODC, the INCB, the WHO and other relevant United Nations entities, within their respective mandates, including those relevant to the above-mentioned issues, and relevant regional and international organizations, as well as with civil society and the private sector, as appropriate'.
- Paragraph 7.l. 'Promote partnerships and innovative cooperation initiatives with the private sector, civil society and international financial institutions to create conditions more conducive to productive investments targeted at job creation in areas and among communities affected by or at risk of illicit drug cultivation, production, manufacturing, trafficking and other illicit drug-related activities in order to prevent, reduce or eliminate them, and share best practices, lessons learned, expertise and skills in this regard'.

Several recommendations within the UNGASS Outcome Document recognise the role of civil society, and encourage their meaningful participation, in drug policy design and implementation (paragraphs 1.q, 4.a, 7.l and 9). In paragraph 9 in particular, member states 'resolve to take the steps necessary to implement the above-listed operational recommendations, in close partnership with the United Nations and other intergovernmental organizations and civil society'. The preamble of the Outcome Document also 'note[s] that affected populations and representatives of civil society entities, where appropriate, should be enabled to play a participatory role in the formulation, implementation, and the providing of relevant scientific evidence in support of, as appropriate, the evaluation of drug control policies and programmes' (although the addition of 'where appropriate' and 'as appropriate' in this sentence shows the ongoing tension between


member states on the level and value of civil society involvement).

The Vienna-based UN drug control system has long been criticised when it comes to civil society and community involvement, especially in comparison with other UN institutions outside Vienna. Much has changed and arguably improved in the past decade(s),[454] as reflected in the process leading up to the 2016 UNGASS itself, during which a Civil Society Task Force (CSTF) was established and played a major role – including, for the first time in history of UN drug policy making, direct representation of farmers of crops deemed illicit.[455] However, it is important to note here that the general processes for civil society engagement in Vienna are now far better structured and delivered in comparison to those which had been established for the 2016 UNGASS itself, which had left many civil society representatives out of the UN building while the UNGASS was taking place.[456]

In 2019, the CSTF served once again as a platform facilitating civil society participation leading up and during the CND Ministerial Segment, as supported by a Memorandum of Understanding between the Vienna and New York NGO Committees on Drugs. In preparation for the 2019 Ministerial Segment, the

CSTF organised two Civil Society Hearings in New York and Vienna, and a global civil society consultation involving 450 organisations – after which a Conference Room Paper was submitted by Switzerland on behalf of the CSTF.[457]

As part of the follow up to the 2019 Ministerial Segment, civil society speakers are invited to participate in all the thematic CND intersessional meetings planned between 2019 and 2023 on the implementation of the Ministerial Declaration. However, the way in which these meetings – and civil society contributions – will feed into the mid-term review of implementation in 2024 remains unclear.

The publication of the UN System Common Position on drug-related matters in 2018 also marks an important milestone, constituting a significant and unprecedented improvement in cooperation among UN entities, and a potentially broader and more meaningful involvement of civil society and communities, 'including people who use drugs, as well as women and young people'.[458]

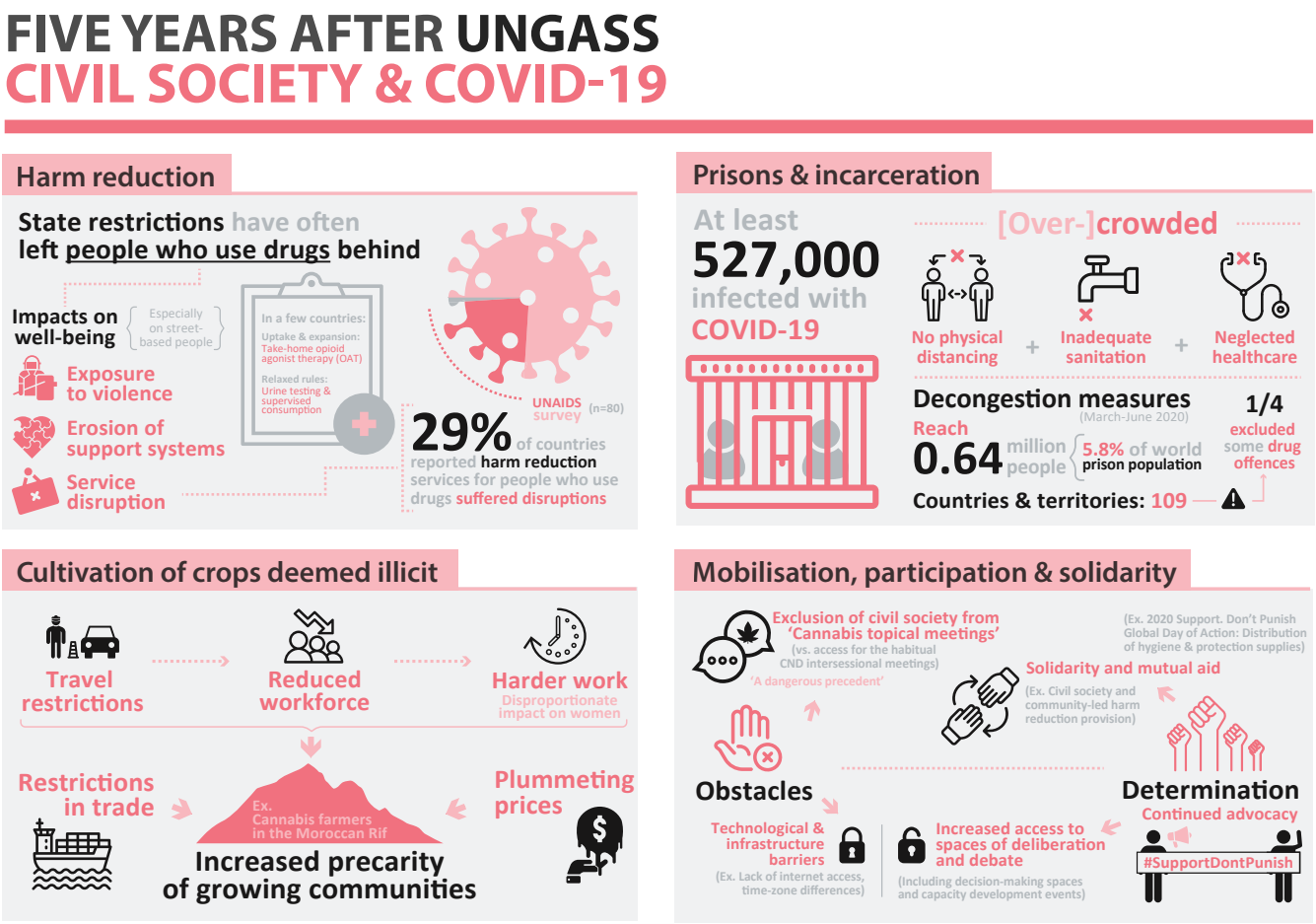
Nonetheless, civil society continues to be left out in some major local, national and global drug policy making processes, especially communities whose lives are most affected by drug policies.[459] For example, while civil society was deeply involved in the drafting and review of the new UNAIDS Global AIDS Strategy for 2021-2026, the UNODC strategy process has so far failed to meaningfully involve civil society and communities.

Other setbacks at the global level should be noted in this regard, especially concerning the exclusion of civil society in the so-called CND 'Topical Meetings' on cannabis scheduling. Unlike usual intersessional meetings, these Topical Meetings were held online due to COVID-19 restrictions, using the 'informal' format which excludes civil society from the debates. IDPC raised concerns that the exclusive nature of these proceedings might constitute a 'dangerous precedent' which could be used in the future for other potentially controversial topics related to drug control.[460]

More generally, serious concerns have been raised over the 'hybrid' (i.e. predominantly online) format of the 64th session of CND in 2021 with fears that civil society engagement will be much more restricted than in the past in terms of numbers of NGO representatives able to participate, as well as opportunities to deliver statements, to observe all proceedings (including negotiations of resolutions), and more – instead of this online format being used as an opportunity to involve more participants who would usually not be able to travel to Vienna.[461] Virtual civil society participation of any form will also require NGO representatives to adapt their advocacy strategy, both at CND and in all other UN forums going forward.[462]

> **"Being in a [Zoom] breakout room with a member state representative can feel more intimate than being in a massive UN building, but side conversations are also lost in virtual spaces."**
>
> **Civil society respondent interviewed for *Innovation and resilience: Civil society advocacy for drug policy reform under the COVID-19 pandemic*[36]**

## 5.2 Civil society and community involvement in service delivery and national-level advocacy




The UNGASS Outcome Document includes a recommendation (1.q) on civil society involvement in drug dependence treatment, rehabilitation, recovery and social reintegration; as well as in the prevention, treatment and care of HIV/AIDS, viral hepatitis and other blood-borne infectious diseases. It is well-documented that the involvement of people who use drugs (peers) in harm reduction and HIV service design and delivery has many benefits. According to a literature review published in February 2021, the active involvement of peers helps ensure the continuity of harm reduction and HIV services as well as of related advocacy that supports such services. More importantly, in the midst of prevailing stigma and criminalisation related to HIV and drug use, peer involvement improves accessibility, 'acceptability and quality of harm reduction services and decrease[s] stigma and discrimination'.[464] This assertion is also reflected in a 2017 document jointly published by several UN entities in collaboration with civil society organisations and entitled 'Implementing comprehensive HIV and HCV programmes with people who inject drugs: Practical guidance for collaborative interventions'.[465]

However, peer-led harm reduction services are still lacking in many parts of the world, and when they exist, they often struggle to sustain themselves. For instance, in northern Mexico, a peer network for naloxone distribution was created by civil society organisations, but until now remains 'unofficial' and unfunded. In the wider region of Latin America and the Caribbean, HIV prevention and treatment – as well as 'peer-to-peer work' remains limited.[466] In Kyrgyzstan, local requirements state that only workers

with at least one year of experience can apply for outreach work positions, thereby creating a (legal) barrier for peers to be involved. Such barriers can be observed in other countries where criminalisation remains so prominent that it obstructs affected groups like people who use drugs from playing an active role in the provision of health services.[467]

Meanwhile, a positive development can be found in Estonia, with the SUTIK programme – mentioned above. The programme was created in 2017 in response to the worsening overdose crisis in the country, and aims to empower and involve people who use drugs in peer-to-peer counselling, support, and referrals – facilitated by police officers. The involvement of peers in the programme – referred to as 'support persons' – goes hand in hand with support provided by psychologists and social workers. The programme has shown that the active role of peers has helped build 'constructive relationships' which were instrumental to create linkages with various health and social services which clients may need or wish to access. Though not without its challenges, the SUUTIK programme has recently been expanded to reach (formerly) incarcerated people who use drugs.[468]

## 5.3 Civil society and community mobilisation at times of COVID-19

In the context of the COVID-19 pandemic, civil society and community-led organisations have remained highly active in ensuring that harm reduction continues to reach people in need, especially during lockdowns and other forms of movement restrictions, guided by solidarity and mutual aid at local, national and international levels. The South African Network of People Who Use Drugs, for example, has supported street-based people who use drugs by distributing needles and syringes, stimulant packs, hygiene and educational materials, and symptomatic medication packs for those experiencing opioid-related withdrawal.[469] Similar initiatives have been undertaken by the West Africa Drug Policy Network (consisting of more than 600 civil society organisations). Meanwhile in Ukraine, NGOs are actively involved in the home delivery of antiretroviral, tuberculosis and hepatitis C medications, in addition to playing a key role in pushing for the expansion of take-home OAT in the country.[470] More examples can be found in Tanzania, Senegal, Iran, and Kenya.[471]

The Support. Don't Punish Global Day of Action on 26 June 2020 also saw a range of local partners organise varied events in 239 cities across 90 countries. Among them, women activists in Dar es Salaam mobilised to collect and distribute hygiene supplies for local communities. Similarly, activists in Cameroon joined forces to distribute meals and COVID-19 prevention materials for street-based people who use drugs.[472]

> **"We are one of the few NGOs who obtained work [and movement] permits quite quickly in order to continue services. Other NGOs have not been this fortunate… We managed to maintain a really close relationship with institutions, and because of the work we've been doing for several years, our work and expertise is recognised".**
>
> **Civil society respondent from Mauritius, interviewed for *Innovation and resilience: Civil society advocacy for drug policy reform under the COVID-19 pandemic*[473]**

In addition to these and hundreds of other community-oriented activities organised in 2020, civil society and community-led organisations have continued to advocate for drug policy reform at all levels, in spite of new challenges brought about by the COVID-19 pandemic.[474] Interestingly, restrictions in travel and in-person meetings, which in some cases have led to the digitisation of events, have to some extent reduced – or rather blurred – technical barriers to civil society and community participation in policy making processes, including at the global level.[475]

> **"Together, our voices are louder, our collective message stronger, our capacity to make change unstoppable. Support. Don't Punish!"**
>
> **Extract from *Solidarity that cannot be confined*[476]**

## 5.4 Civil society and the private sector

Such changes have not resolved larger and more far-reaching structural barriers which have long prevented those 'most affected' from meaningfully participating in advocacy and policy making processes. This issue taps into existing power imbalances between groups equally seen as 'stakeholders' – a concept initially used in the corporate world.[477] Indeed, the UNGASS Outcome Document promotes 'partnerships and innovative cooperation initiatives *with the private sector*, civil society and international financial institutions' (paragraph 7.i, emphasis added). In line with this, in 2020, the CND adopted Resolution 63/1 'Promoting efforts by Member States to address and counter the world drug problem, in particular supply reduction-related measures, through effective partnerships with private sector entities'.[478]

The growing prominence of the private sector in policy making has also sparked concerns. In the 2019 'Partnership framework that brings together the UN and the World Economic Forum' in pursuit of the SDGs, as well as in other policy making spaces, 'the private sector' is placed alongside groups such as civil society and affected communities. This approach fails to recognise the fact that actors equally labelled as 'stakeholders' consist of groups with varying backgrounds as well as conflicting needs and interests. The 'stake' of transnational corporations is inevitably very different from that of affected and criminalised communities such as people who use drugs and landless rural workers in cultivation. While the former has a profit-maximising 'stake', the latter has a set of needs and rights which are often neglected and violated.[479]

The damaging impact of this trend can already be observed in countries where cannabis policy reform is taking shape. From Colombia to Canada to South Africa, traditional farmers as well as others whose lives have been negatively impacted by the war on drugs, have mostly been excluded from debates on the legal regulation of cannabis in which corporations and investors increasingly gain access to licenses, lands, and resources supportive of their profit-maximising interests.[480] Certain international mechanisms such as the CSTF, as well as many others facilitated by international civil society groups and networks, have helped to open up the space for marginalised groups to take part in advocacy and policy making processes. However, social and economic inequalities and disparities, combined with elements of discrimination, criminalisation and injustice upheld by various laws and policies, continue to serve as barriers to meaningful participation.[481]

# Notes

# Part 6

## Improving UN agency collaboration and coordination

**Relevant UNGASS recommendations:**

- Paragraph 1.r. 'Encourage the UNODC and the ICB to strengthen cooperation with the WHO and other competent United Nations entities, within their respective mandates, as part of a comprehensive, integrated and balanced approach to strengthening health and social welfare measures in addressing the world drug problem'.
- Paragraph 4.a. 'Enhance the knowledge of policy-maker (…) and to that end encourage cooperation with and among the UNODC, the INCB, the WHO and other relevant United Nations entities, within their respective mandates, including those relevant to the above-mentioned issues (…)'.
- Paragraph 5.w. 'Encourage the Commission on Narcotic Drugs, in cooperation with relevant United Nations entities, within their respective mandates, to consider, as appropriate, reviewing existing guidelines and, where required, developing new ones on the various aspects of the world drug problem (…)'.
- Paragraph 5.y. 'Call upon the UNODC, the INCB, the WHO and other United Nations entities with pertinent technical and operational expertise, within their mandates, to continue to provide, upon request, advice and assistance to States that are reviewing and updating their drug policies (…)'.
- Paragraph 6.a. 'Strengthen specialized, targeted, effective and sustainable technical assistance (…) to requesting countries, including transit countries, through and in cooperation with the UNODC , as well as the WHO and other relevant United Nations entities and (…( to assist Member States to effectively address the health, socioeconomic, human rights, justice and law enforcement aspects of the world drug problem'.
- Paragraph 6.d. 'Encourage the Commission on Narcotic Drugs to contribute to the global follow-up and support the thematic review of progress on the Sustainable Development Goals'.
- Paragraph 6.e. 'Encourage the CND and the UNODC to further increase cooperation and collaboration with all relevant United Nations entities and international financial institutions, within their respective mandates, when assisting Member States in designing and implementing comprehensive, integrated and balanced national drug strategies, policies and programmes.'

With many references to the need for greater cooperation between the UNODC, the CND and other UN entities, the 2016 UNGASS Outcome Document provides a clear and explicit mandate to increase the unity of action and purpose of the UN system on drug-related matters. Five years later, coordination across UN entities on drug policies has made previously unthinkable progress, chiefly through the 2018 UN System Common Position on drug-related matters,[482] but remains far from complete.

For decades, the international drug control system established by the UN drug conventions was developed and implemented with a significant degree of isolation from other UN institutional and normative environments – notably those related to health, human rights, and sustainable development. In practice, this meant that, for years, Vienna-based institutions such as the UNODC, the INCB and the CND enjoyed a monopoly over UN-level drug policy making, with important consequences.

The 2016 UNGASS and its Outcome Document constituted a major breakthrough[483] by legitimising the role of the broad range of UN entities in drug policies, and in seeking broader coherence and cooperation on all dimensions of drug policies across the UN system. This was underscored by the very process leading up to the adoption of the Outcome Document itself, which included contributions by over a dozen UN entities, from the Human Rights Council to UNDP, UN Women or the UN Office for Disarmament Affairs.[484] In the five years after UNGASS, the effort to seek broader UN system cooperation and coherence has continued to gain momentum.

# 6.1 The UN System Common Position on drug-related matters

In the past five years, the main breakthrough in advancing UN coherence and cooperation has been the adoption, in November 2018, of the UN System Common Position on drug-related matters. Adopted at the initiative of the UN Secretary General by the UN Chief Executives Board, a body that brings together the chief executive officers of all 31 UN agencies (including the UNODC, WHO, OHCHR, and UNDP among many others), the Common Position represents a joint commitment by all UN agencies to support member states 'in developing and implementing truly balanced, comprehensive, integrated, evidence-based, human rights-based, development-oriented, and sustainable responses to the world drug problem, within the framework of the 2030 Agenda for Sustainable Development'.[485]

> **"In 2018, thirty-one principals of UN entities adopted a UN System Common Position to provide coordinated support to States in drug-related matters. Through a public health and human rights lens, the Common Position provides guidance for actions, including shifting drug policies and interventions toward a public health approach and ensuring respect for human dignity and human rights. The Common Position provides a framework to work together to ensure that no one is left behind, including in the drug control context."**
>
> **Ilze Brands Kehris, United Nations Assistant Secretary-General for Human Rights[486]**

The UN System Common Position provides 'authoritative guidance'[487] to all UN agencies on a broad range of matters, in line with the principles set in the 2016 UNGASS Outcome Document, the SDG framework, and the UN human rights system. It commits all UN entities – including the UNODC – to support issues like the decriminalisation of people who use drugs, harm reduction and rights-based development programmes.

From an operational point of view, the Common Position also created the UN system coordination Task Team, an inter-agency panel of representatives of interested UN entities to 'identify actions to translate the common position into practice'.[488] In March 2019, the Task Team produced its first report, which provides a useful overview of the knowledge and data gathered by the different entities within the UN system on drug-related matters.[489]

While the Common Position has been a crucial development, its dissemination and implementation have faced serious challenges. Many member states welcomed the Common Position, and have since supported it strongly through country statements,[490] CND side events, and by including it in their own drug strategies, as is the case for the EU.[491] However, others have been critical of the Common Position and the work of the Task Team, with the argument that they might seek to replace or undermine the CND in its policy making functions.[492] It is worth noting that these states are also the most reticent to the inclusion of human rights, health and development in drug policy considerations.

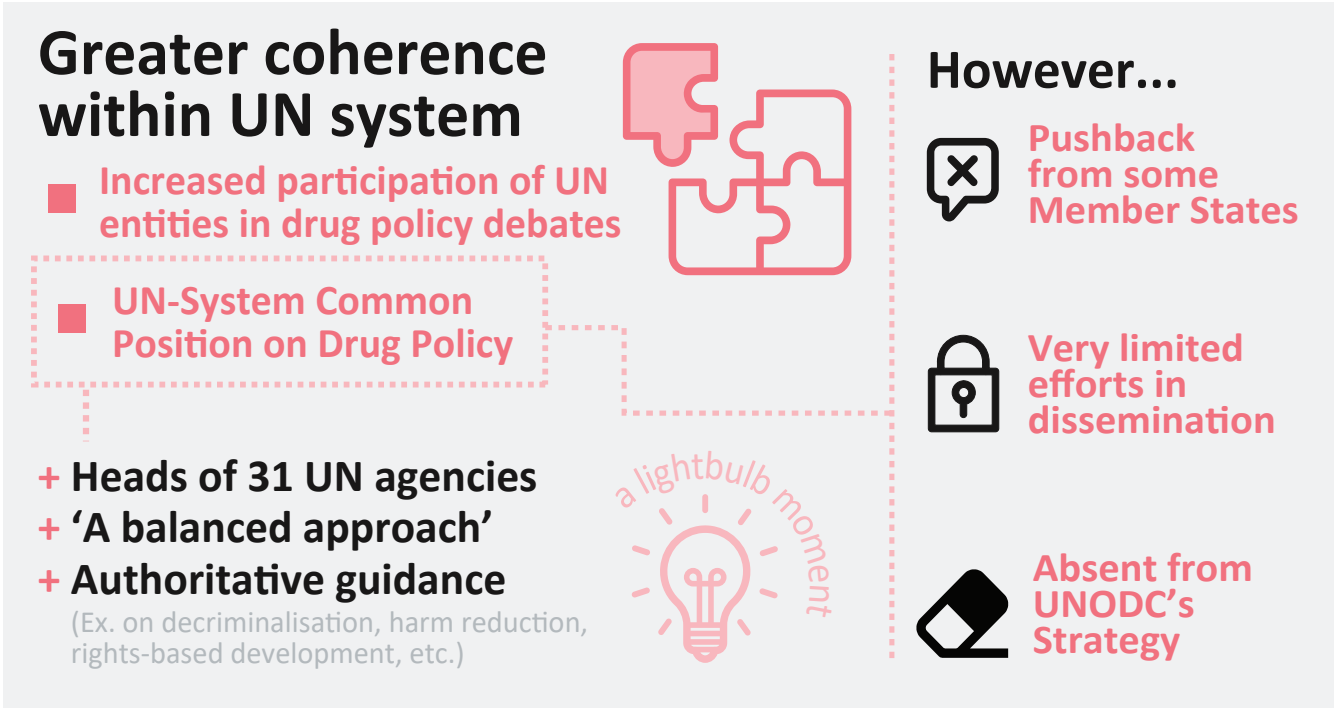
As a result, the Common Position remains very poorly publicised, and largely unknown across UN entities, member states and civil society. In spite of some efforts to disseminate it amongst UN resident coordinators,[493] it is yet to be published as a standalone document, or to be translated into all UN languages. Inexplicably, the Common Position is also absent from the new UNODC Strategy for 2021-2025,[494] and the UNODC performance as the leading agency for the dissemination of the Common Position is frequently regarded as underwhelming. Efforts to disseminate it and translate it into concrete policies and practice will be at the forefront of civil society efforts calling for system-wide coherence in the coming years.

## 6.2 Integrating other UN entities within the Vienna

Within the framework of the 2016 UNGASS Outcome Document, the CND remains the 'policymaking body with primary responsibility for drug control matters', while the UNODC is the 'leading entity' on the subject.[495] However, it is increasingly clear that other UN entities based in Geneva and New York should engage with debates and policy making within the Vienna setting itself.

In that regard, progress has been made in the past five years. Geneva bodies had a strong presence in the Vienna-based debates leading up to the 2019 Ministerial Segment, with a contributing Resolution by the Human Rights Council,[496] a resulting OHCHR report on the implementation of the UNGASS Outcome Document,[497] and statements issued by five human rights special mandates ahead of the Segment.[498] In 2018, the Chair of the Committee on the Elimination of Discrimination against Women addressed CND in that capacity for the first time in the history of the Commission,[499] and the same happened in 2019 for the Chair of the UN Working Group on Arbitrary Detention.[500]

The UNODC has also recently adopted Memorandums of Understandings with entities like the WHO (in 2018),[501] and the Global Fund (in 2021). However, no agreement has been signed with the OHCHR, and the presence of this crucial office in Vienna remains limited as a result, as efforts to set up a liaison officer in Vienna have yet to come to fruition.



## 6.3 The other side of coherence: Drug policies outside Vienna

In the past five years, the voices of UN entities other than the UNODC on the aspects of drug policy that fall within their mandates have grown stronger and more influential. To point out just two: the International Guidelines on Human Rights and Drug Policy,[502] launched in 2019, constitute the first authoritative international standards on this topic; and a year later, UNAIDS published a watershed report[503] on health, human rights and drugs, with strong recommendations for harm reduction and the decriminalisation of people who use drugs – recommendations that have been reflected in the UNAIDS Global AIDS Strategy for 2021-2026.[504]

When it comes to the human rights system, the space for drug-related matters has steadily grown in the work of UN treaty bodies and special procedures. In that regard, since 2018 the UN Committee on Economic Social, and Cultural Rights has consistently integrated drug policies in its country reviews,[505] while drug-related matters are also frequently incorporated in the recommendations of the UN Committee on the Elimination of Discrimination Against Women.[506] At the same time, the UN Working Group on Arbitrary Detention is set to present its first ever report dedicated to drug policies and arbitrary detention at the Human Rights Council in June 2021.[507] Encouragingly, an increasing number of national human rights institutions are involved in drug-related matters, and a significant number of them responded to the OHCHR's call for inputs ahead of their 2018 report on UNGASS implementation.[508]

> **"Data and experience clearly demonstrate that so called punitive action or 'war on drugs' has failed and is not the solution. The harmful consequences of such an approach are deep and far-ranging: more violence, more human rights violations, abuses, and public health failure. The Common Position provides several directions of action, including the creation of policies centred on people, health, and human rights, shifting drug policies and interventions towards a public health approach, and ensuring respect and human dignity for people who use drugs."**
>
> **Zaved Mahmood, United Nations Office of the High Commissioner for Human Rights[509]**

Important political challenges remain in Geneva. Since its 2018 resolution, the Human Rights Council has been slow in prioritising and engaging with drug-related matters, as illustrated by the overwhelming lack of recommendations on drug-related topics in the Universal Periodic Review procedure,[510] or by the controversial[511] October 2020 Resolution on the Philippines,[512] which has been criticised for failing to recognise the gravity of the human rights violations associated to the 'war on drugs', and for ignoring calls for an international investigation made by UN experts and civil society.[513] Similarly in New York, little visibility has been given to drugs issues at the High Level Political Forum and discussions around the SDGs. To fulfil the commitments of the UNGASS Outcome Document, an increased focus on this in the coming years will be critical.

# Notes

# Part 7

## The quest for new indicators to evaluate drug policy success

# 7.1 A revised Annual Report Questionnaire (ARQ)

**Relevant UNGASS recommendations:**

- Paragraph 3.c. 'Promote data collection, research and the sharing of information, as well as the exchange of best practices on preventing and countering drug-related crime and on drug supply reduction measures and practices (…)'.
- Paragraph 3.e. 'Monitor current trends and drug trafficking routes and share experiences, best practices and lessons learned (…)'.
- Paragraph 4.h. 'Consider, on a voluntary basis, when furnishing information to the Commission on Narcotic Drugs pursuant to the three international drug control conventions and relevant Commission resolutions, the inclusion of information concerning, inter alia, the promotion of human rights and the health, safety and welfare of all individuals, communities and society (…)'
- Paragraph 5.p. 'Support research, data collection, analysis of evidence and sharing of information (…), to prevent and counter drug-related criminal activities using the Internet, consistent with relevant and applicable law'.
- Paragraph 5.x. 'Promote exchange of information to better understand the extent of adverse impacts of drug trafficking in small quantities to develop effective responses to counter microtrafficking'.
- Paragraph 7.g. 'Promote research (…) to better understand factors contributing to illicit crop cultivation, taking into account local and regional specificities, and to improve impact assessment of alternative development programmes, (…) including through the use of relevant human development indicators, criteria related to environmental sustainability and other measurements in line with the Sustainable Development Goals'.

Various UNGASS recommendations refer to the need for improved data collection (paragraph 3.c), research and analysis of evidence (paragraph 5.p), monitoring of trends (paragraph 3.e) and exchange of information (paragraph 5.x). The Outcome Document also promotes the 'use of relevant human development indicators, criteria related to environmental sustainability and other measurements in line with the Sustainable Development Goals' (paragraph 7.g), and asks member states to 'consider, on a voluntary basis,… the inclusion of information concerning, inter alia, the promotion of human rights and the health, safety and welfare of all individuals, communities and society' (paragraph 4.h). This is a welcome departure from the traditional data being collected almost exclusively on the scale of the illegal drug market.

Between 2018 and 2020, the UNODC has embarked in the challenging task of revising its main data collection mechanism to measure drug markets and policies – the Annual Report Questionnaire (ARQ) – in part to reflect key elements from the UNGASS Outcome Document. The need for an improved ARQ was strongly called for by civil society in the aftermath of the UNGASS, both to reflect the new components focusing on health, gender, human rights and development, but also to measure success in drug policy against progress made towards the core principles of the UN system: protecting human rights, promoting peace and security, and advancing development.[514] This, in particular, would involve evaluating progress towards the achievement of the SDGs.

After two years of expert meetings and negotiations, the revised ARQ[515] was adopted by consensus at the 63rd session of the CND in March 2020.[516] Undeniable progress was made in the new ARQ to ensure that data collected not only measures the overall scale of the illegal drug market, but also levels of health-related harms, access to harm reduction and treatment programmes, utilisation of alternatives to incarceration, numbers of people incarcerated for drug offences – most of which are now disaggregated by age and sex. Disappointedly, however, the

> **"Ensuring that governments are held responsible for protecting human rights through drug laws, policies and strategies requires tracking data and conducting regular assessments of the human rights situation as it relates to drug control."**
>
> **Excerpt from the 2018 OHCHR report on UNGASS implementation[517]**

**Annual Report Questionnaires**

**Recently improved**
**especially in relation to:**

+ **Health-related harms**
+ **Access to harm reduction & treatment**
+ **Alternatives to incarceration**
+ **# of people in prison**

**Fails to incorporate:**

- **Human rights impacts of drug control**
- **SDGs**
- **Data from other UN agencies**
  (Ex. UNAIDS, WHO, OHCHR, UNDP)
- **Civil society data, analysis & research**
- **Voices from affected communities**

ARQ as it currently stands fails to truly evaluate the overall impacts of drug policies on human rights, and does not refer to the SDGs (although previous drafts of the document had done so). This is despite the recommendation by the OHCHR that the success of drug control strategies should be measured through an assessment of the impact of drug control efforts in the enjoyment of human rights and other critical aspects such as security, health and socioeconomic development'.[518]

## 7.2 The UN implementation Task

In this context, the establishment of the UN System Task Team is a welcome step forward. The Common Position on drug-related matters commits the UN to 'compile, analyse and produce data reflecting United Nations system-wide practices and lessons-learned in drug-related matters, and to produce systemwide data and analysis, including in the light of the 2019 ministerial segment of the Commission on Narcotic Drugs and the advancement of the implementation of the 2030 Agenda'. The Task Team itself was established 'With a view to ensuring coherent efforts to realize the commitments set out in this common position and, in particular, coordinated data collection to promote the scientific, evidence-based implementation of international commitments'.[519]

UN entities such as UNAIDS, WHO, OHCHR and UNDP have significant experience and expertise in data collection that could be used to better understand the impacts of global drug policies – as was shown in the UN Task Team report published in 2019 'What we have learned over the last ten years: A summary of knowledge acquired and produced by the UN system on drug-related matters'.[520] However, the UNODC's leadership of the Task Team has so far been disappointing, with little progress made to date on ensuring coordinated efforts for data collection on drug-related issues across the UN family. The lack of funding allocated to the Task Team's work has been one of the various factors hampering progress in this regard. Until the Task Team is empowered and adequately funded to play a key role in coordinating data collection, it is unlikely that measurements of drug control will dramatically change for the better.

## 7.3 A key role for civil society

Civil society has an essential role to play in data collection, research and analysis by bringing additional or alternative data and information to the table, filling gaps (including when there is unwillingness to conduct research on failed policies), or providing context, critique and nuance to governments' own data. Furthermore, civil society also provides qualitative research and brings the voices and lived experiences of affected communities to the discussion. These are critical to obtain a full picture of what impacts drug policies truly have on communities on the ground. The IDPC Shadow Report 'Taking stock: A decade of drug policy' is one such example – faced with the unwillingness from governments and the UNODC to meaningfully assess progress made over the past decade of global drug control in the lead up to the 2019 Ministerial Segment, civil society filled this important gap and called upon the expertise of its network to produce the analysis.[521]

> **"We are five years into when the historic 2016 UNGASS Outcome Document on Drugs was passed by member states. Shockingly, it was the first time that human rights had been mentioned in a high-level multilateral document on drugs, demonstrating how far behind and out of touch the world's thinking and actions on drug policies has been. The rights of people who use drugs should not continue to be superseded by drug control objectives, which we have seen all too often, prior and post 2016. Even though some member states have made progress towards implementation, this has remained starkly inadequate and uneven. If we are to move forwards and hold member states to account, a strong community and civil society response is needed. This response starts with community-driven data generation, implementation and monitoring, which must be adequately resourced. Communities, whose lives are most directly impacted by drug policies and programmes are best placed to report on the impacts of those same policies on our lives, as well as shape and inform the development of future policies and programmes."**
>
> **Judy Chang, Executive Director, International Network of People Who Use Drugs[522]**

Currently, civil society involvement in UN data collection efforts is severely limited. NGO consultations on the ARQ revision progress were limited to an online questionnaire, but no civil society experts were invited to attend any of the expert meetings.[523] And although civil society is consulted by the UNODC regarding harm reduction data to include in the World Drug Report, NGOs are not able to feed into any other section of the report. In this respect, the UNODC lags far behind other UN agencies such as the OHCHR which systematically launches open calls for contributions for its upcoming reports.

In an effort to address this issue, various civil society organisations and academics have embarked in the ambitious task of developing the first Global Drug Policy Index, which would aim to increase transparency in decision making processes around drugs, promote new human rights indicators to evaluate drug policy, and facilitate the participation of civil society in data collection in support of more humane drug policies. The Index will be released in autumn 2021.[524]

# Notes

# Part 8

## Conclusions and recommendations

This review of the five years of implementation of the UNGASS Outcome Document shows that much remains to be done to ensure that drug policies are fully aligned with human rights, health promotion and the 2030 Agenda for Sustainable Development.

Some progress has undeniably been made in some aspects of global drug policy. For instance, the shift in rhetoric from a narrow alternative development and crop eradication focus to a sustainable development approach to drug policy is to be welcome. In the area of international cooperation and system-wide coherence within the UN family, the adoption of the UN System Common Position on drug-related matters and the creation of its implementation Task Team constitute important milestones in ensuring that drug policy is better aligned with the broader objectives of the UN to promote human rights, advance development and ensure peace and security. Various countries and jurisdictions have also decriminalised drug use and possession for personal use, improved access to opioids and cannabis for medical purposes, scaled up harm reduction services, adopted decarceration measures and implemented sustainable livelihoods programmes.

Yet, available data and testimonies from the ground show that this is not enough, and the gap between rhetoric and meaningful change for communities affected by punitive drug control is widening. People who use drugs continue to be criminalised in most countries around the world, and their access to life-saving harm reduction and treatment services remains unjustifiably restricted. People continue to be incarcerated in overcrowded prisons for disproportionate amounts of time for low-level, non-violent drug offences. Access to essential medications for the treatment of pain and palliative care is being denied to billions of people in need. Farmers cultivating plants destined for the illegal drug market face forced eradication, health harms caused by the use of chemicals, violence at the hands of law enforcement and military forces, and find themselves in situations of poverty and marginalisation with too little support from their government. People suspected of drug offences are victims of police violence, extrajudicial killings and may face the death penalty in various countries. Groups in situations of vulnerability, in particular women, youth, ethnic minorities and the poor remain disproportionately affected by repressive drug control. In parallel, civil society space is increasingly being restricted at both national and international levels. Many of these challenges have been exacerbated by the COVID-19 pandemic and government measures adopted to curb infection rates.

On balance, the positive progress observed in some countries and jurisdictions has not been able to counterbalance the lack of progress made in others – nor the concerning moves towards even more repressive approaches in countries such as Brazil, Colombia, Hungary, the Philippines, Russia and others since 2016.

Furthermore, it should be recalled that various critical aspects of drug policy were not reflected in the UNGASS Outcome Document, due to the consensus-based nature of the negotiations. These include, for instance, human rights issues such as the death penalty and extrajudicial killings, as well as the issue of cultural and traditional rights beyond the scope of UNDRIP. In addition, although the UNGASS Outcome Document puts welcome emphasis on the needs and vulnerabilities faced by women, it fails to consider those faced by the LGBTQ+ community. Similarly, the Document does not mention the need for a social justice approach to all aspects of drug policy, and remains silent on moves towards legal regulation. The latter is particularly problematic as more and more jurisdictions are moving towards legally regulated markets for cannabis, without an honest and genuine debate on how this is affecting the international drug control regime as it currently stands.

**This bleak picture of the global state of play highlights the need for urgent reforms, both globally and at national level. Below, we propose some key recommendations for policy makers for the coming five to ten years of drug policy. These recommendations will require courage to move away from the status quo, in order to truly address, and redress, the ongoing harms caused by punitive drug control on all affected communities worldwide.**

## 8.1 Recommendations for global drug policy reform

- Ensure the meaningful participation of civil society, in particular affected communities, in global drug policy making, implementation, monitoring and evaluation, and actively promote civil society space via institutionalised channels for participation, identifying and addressing obstacles to participation, joint strategic actions, and political and financial support.
- Ensure that the UN System Common Position becomes the go-to document to guide country, regional and global UN planning processes, and that its recommendations are prioritised for technical support. To achieve this, ensure that the Common Position is disseminated widely to all focal points within UN agencies and at regional and national level, including through the resident coordinator system, and create a new position at the office of the UN Secretary General to implement the Common Position, support the Task Team, and enhance UN coordination on drug-related matters.
- Ensure that the Task Team in charge of implementing the Common Position is provided with sufficient budgetary resources, space and political support to carry out its mandate, and to report back on its activities at every CND, as well as other relevant UN fora.
- Ensure that all relevant UN agencies, including the WHO, OHCHR, UNAIDS, UNDP, UN Women and others, are meaningfully involved in CND discussions and other drug-related UN meetings.
- Ensure that the health, human rights, and development aspects of drug policy are systematically raised and discussed in relevant UN fora in Vienna, New York and Geneva.
- Mark the 5th anniversary of UNGASS with a resolution at the Human Rights Council on best practices and challenges associated with the implementation of the UNGASS Outcome Document. This resolution should request the OHCHR to prepare biannual reports to the Human Rights Council on this topic, and mandate the Office to share them with other UN entities, including the CND.
- Ensure that the World Drug Report reflects the multiple dimensions of the world drug situation, by establishing a mechanism that allows all UN agencies, civil society and the Task Team to provide annual data and information to feed into this document.
- Ensure that the WHO's ECDD is adequately funded to meet regularly and conduct regular reviews on substances such as cannabis, but also coca and others.

## 8.2 Recommendations for national drug policy

### Ensuring a public health approach to drug policy

- Improve access to, and sustainable funding for, harm reduction and evidence-based drug dependence treatment for people who use drugs, including women and youth, both in the community and in prisons.
- Improve women's access to gender-sensitive drug services, tailored to their specific needs and circumstances.
- Address the legal impediments to harm reduction, treatment and other services, including criminalisation of drug use, of drug use paraphernalia, as well as stigma and discrimination.
- Establish national-level quality standards for the provision of treatment services aligned with international standards, as well as mechanisms to evaluate programmes according to international human rights guidelines.
- Ensure that drug services are considered as 'essential' and continue operating under COVID-19 restrictions, and that people who use drugs are not left behind in vaccination programmes.
- Remove legislative, political, economic, cost and technical barriers that hamper access to controlled medicines for scientific and medical purposes, including bans on methadone, limited availability of opioid medication, lack of training and medical personnel to prescribe medicines, and others.

### Ensuring a development-oriented approach to drug policy

- Ensure cross-sectoral collaboration in designing, implementing and evaluating development-oriented drug policies, to support the process of broadening the scope of such policies – moving away from a narrow alternative development approach focused on forced eradication to a sustainable development approach that truly seeks to address the poverty, marginalisation and lack of access to land and basic services faced by farmers on the ground, in line with the SDGs, taking into account the complexity of drug and related economies.
- Ensure the meaningful participation of local communities, including indigenous peoples, at every stage of policy development, to make sure that these respond to their specific needs and circumstances.
- Ensure that women benefit meaningfully and directly from development projects, and have a prominent role in the design, implementation, evaluation and monitoring of such efforts.
- Put an immediate end to violent law enforcement practices in areas of illegal cultivation, and redress the human rights abuses committed in the name of drug control.
- Ensure adequate sequencing for any crop reduction strategy, so that alternative sources of income are in place prior to any crop reduction effort, which should be voluntary and implemented in close collaboration with local communities.
- Apply an inclusive development approach at all levels in all aspects of drug policy, including in urban areas, in order to address the cycles of poverty, inequalities and marginalisation faced by people involved in drug offences.
- Recognise the cultural, traditional and ancestral rights of local communities to grow and use controlled plants.
- Adopt environmental policies aimed at protecting zones affected by illegal cultivation to ensure that drug policies do not further cause environmental and health hazards.

### Ensuring a human rights-based approach to drug policy

- Remove all punishment for drug use, possession and cultivation for personal use.
- Reform drug laws and policies to remove mandatory pretrial detention and minimum sentences for drug offences, in law and in practice

– ensuring that prison is only used as a measure of last resort.

- Ensure more proportionate penalties and sentencing practices for drug offences, including via the consideration of mitigating circumstances.
- Develop and provide meaningful alternatives to incarceration and punishment for drug offences.
- Ensure timely access to justice and reparations for victims of human rights abuses committed in the name of drug control.
- Ensure access to free or affordable legal aid, as well as interpretation and consular services if needed, for all of those accused of drug offences.
- Abolish the death penalty in all circumstances, and ensure that penalties for those currently on death row are commuted to a sentence commensurate with the severity of the offence.
- Consider adopting legal regulation models based on social justice, human rights, and public health principles, beginning with – but not limited to – substances like cannabis.[525]

## Ensuring the meaningful participation of civil society in drug policy

- Ensure the meaningful participation of civil society – in particular affected communities such as people who use drugs, people who grow crops destined for the illegal drug market, currently and formerly incarcerated people for drug offences, women, LGBTQ+ and youth – in national, regional and international drug policy making, implementation, monitoring and evaluation, including through access to information, funding and non-discriminatory rules preventing their participation.
- Actively promote civil society space, especially community participation in decision making processes, via institutionalised channels for participation, identifying and addressing obstacles to participation, joint strategic actions, and political and financial support.
- Protect civil society actors at risk of intimidation and reprisals, repeal laws and policies that may hamper civil society space, and ensure access to justice for civil society and human rights defenders who have suffered human rights violations as a result of drug control or other governmental policies.
- Acknowledge and support the active role of civil society and communities in harm reduction and other forms of lifesaving services and programmes

## Improving data collection, monitoring and evaluation of drug policies

- Ensure that mechanisms for data collection and analysis on drug policy are established and well-funded at national level.
- Reduce the prominence of indicators focusing on the overall scale of and flows within the illegal drug market, and focus instead on more meaningful indicators measuring progress towards protecting health, improving human rights, welfare, gender equality, reducing levels of violence, etc. (i.e. impact on individuals and communities).
- Ensure the meaningful participation of civil society, including affected communities, in data collection, monitoring and evaluation of drug policies and their intersectionality with gender, HIV, access to justice, development, etc.

# Endnotes

1. Head of Research and Communications, International Drug Policy Consortium
2. Research and Policy Officer, International Drug Policy Consortium
3. Consultant, International Drug Policy Consortium
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This report takes stock of progress made on the implementation of the recommendations included in the UNGASS Outcome Document. Using desk-based research, and drawing on data and analysis from UN reports, academia, civil society and the community, the report focuses on six critical areas: public health, development, human rights, civil society engagement, UN agency collaboration and cooperation, and drug policy evaluation..



The International Drug Policy Consortium (IDPC) is a global network of NGOs that come together to drug policies that advance social justice and human rights. IDPC's mission is to amplify and strengthen a diverse global movement to repair the harms caused by punitive drug policies, and to promote just responses.

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