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**Promotion and protection of all human rights, civil,
political, economic, social and cultural rights,
including the right to development**

Drug use, harm reduction and the right to health

Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, Tlaleng Mofokeng

Summary

In the present report, the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, Tlaleng Mofokeng, explores how harm reduction relates to both drug use and drug use disorders, as well as to drug laws and policies, aiming to analyse and address the related outcomes that adversely impact the enjoyment of the right to health. In doing so, she focuses on drugs whose production, distribution and consumption have been subject to control under the international drug control conventions, including how the approach to such control has negatively affected the availability, accessibility, acceptability and quality of certain drugs used as medicines.

The Special Rapporteur considers harm reduction interventions particularly important for populations that are often stigmatized and discriminated against in the context of drug use and the enforcement of drug laws and policies. She explores how this compounds other forms of discrimination and disproportionately affects certain individuals, such as persons in situations of homelessness or poverty, persons with mental health issues, sex workers, women, children, LGBTIQ+ persons, Black persons, Indigenous Peoples, migrants, persons who are incarcerated or detained, persons with disabilities, persons living with HIV, tuberculosis or hepatitis, and persons living in rural areas. She also examines gaps in harm reduction care, including in contexts in which it fails to meet the needs of those who have borne the brunt of punitive drug laws and policies over decades, such as persons of African descent and Indigenous Peoples.



I. Introduction

1. Drugs have been a part of human history for thousands of years, whether for medicinal healing, religious and cultural ceremonies or as commodities for pleasure.¹ However, across populations and over time, societies have taken vastly different approaches to drugs.

2. The social determinants of health² shape behaviours and outcomes that reflect disparities based on socioeconomic status, ethnicity, race, gender and other factors. Some people turn to drugs as a means of coping with mental health issues, trauma, discrimination and marginalization, such as that experienced by migrants, Indigenous Peoples, racial, ethnic and sexual minorities and LGBTIQ+ persons.³ Societies often further stigmatize people who use drugs rather than dealing with the root causes of the disparities surrounding drug use and the risk factors for drug use disorders. Such stigmatization can lead to the loss of opportunities, including the ability to pursue employment or education, acquire or maintain housing, access social security assistance and gain citizenship or legal status.

3. It is crucial to distinguish between drug use and drug use disorders. Drug use disorders, including drug dependency, are a medical condition that, in particular when left untreated, can increase morbidity and mortality risks for individuals, trigger substantial suffering and lead to impairment in personal, family, social, educational, occupational or other important areas of functioning, thus requiring appropriate treatment.⁴ Drug use is not a medical condition and does not imply dependency.⁵ The majority of people who use drugs do not require treatment. Still, the use of certain drugs without medical supervision can be associated with risk of overdose and death; drug use by injection carries the additional risk of transmitting infections such as HIV, hepatitis and tuberculosis.

4. The political determinants of health, or the norms, policies and practices that arise from political interactions across all sectors and across all geographical borders affecting health,⁶ drive better or worse outcomes across the world, including as they relate to drugs and drug laws and policies.

5. The harms related to drug use have been fuelled by ill-advised legal and political strategies, part of the “war on drugs” led by the global North, which, since the 1970s, has heavily criminalized and stigmatized the production, distribution and consumption of psychoactive drugs, with devastating effects across the globe and particularly in the so-called global South.⁷ Regrettably, the existing international legal framework on drug control has propelled the criminalization of drug use, naming addiction to drugs as an “evil” that States must combat.⁸ In turn, it has influenced States’ drug laws and policies at the domestic level⁹ through stringent punitive measures, including imprisonment or other penalties of deprivation of liberty, as called for in the international framework.¹⁰ However, the risk of harsh punishment has not served as a deterrent to drug use. Moreover, drug laws and policies have resulted in the violation of various human rights, including the right to health, with a disproportionate impact on people who have been made the most vulnerable.

¹ Marc-Antoine Crocq, “Historical and cultural aspects of man’s relationship with addictive drugs”, *Dialogues in Clinical Neuroscience*, vol. 9, No. 4 (2007).

² World Health Organization (WHO), “Social determinants of health”, available at https://www.who.int/health-topics/social-determinants-of-health#tab=tab_1.

³ *World Drug Report 2023: Executive Summary* (United Nations publication, 2023).

⁴ WHO, “Drugs (psychoactive): impact”, available at https://www.who.int/health-topics/drugs-psychoactive#tab=tab_2.

⁵ A/65/255, para. 7. For information on drug use by drug and across regions, see *World Drug Report 2022: Executive Summary – Policy Implications* (United Nations publication, 2022), pp. 26–30.

⁶ Daniel Dawes, “Health inequities: a look at the political determinants of health during the COVID-19 pandemic”, *American Journal of Health Studies*, vol. 35, No. 2 (2020).

⁷ Office of the United Nations High Commissioner for Human Rights (OHCHR), “UN experts call for end to global ‘war on drugs’”, 23 June 2023.

⁸ Single Convention on Narcotic Drugs of 1961 as amended by the 1972 Protocol, preamble.

⁹ A/65/255, para. 9.

¹⁰ 1961 Convention as amended, art. 36.

6. The commercial determinants of health, or the private sector activities that affect people's health, directly or indirectly, positively or negatively,¹¹ also drive health outcomes related to drug use and drug laws and policies. Pharmaceutical companies, driven by profit motives, have played a major role in fuelling the proliferation of prescription opioids and the opioid crisis. Private-sector activities, which prioritize corporate interests over patient interests, have shaped individuals' access to pain management care.¹²

7. Together, the social, political, commercial and legal determinants of health influence environments in which a person may produce, distribute or use drugs and can create and reinforce health disparities. An alternative, evidence-based and public health- and human rights-centred approach to drug use is urgently needed.

8. In the present report, the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, Tlaleng Mofokeng, explores how harm reduction relates to both drug use and drug use disorders, as well as to drug laws and policies, aiming to analyse and address the related outcomes that adversely affect the enjoyment of the right to health. In doing so, the Special Rapporteur focuses on drugs whose production, distribution and consumption have been subject to control under the international drug control conventions and on how that control has negatively affected the availability, accessibility, acceptability and quality of certain drugs used as medicines.

9. She explores how drug control compounds other forms of discrimination and disproportionately affects certain individuals, such as those in situations of homelessness or poverty, people with mental health issues, sex workers, women, children, LGBTIQ+ persons, Black persons, Indigenous Peoples, migrants, persons who are incarcerated or detained, persons with disabilities, persons living with HIV, tuberculosis or hepatitis and persons living in rural areas. She examines gaps in harm reduction care, including in contexts in which it fails to meet the needs of those who have borne the brunt of punitive drug laws and policies over decades, such as persons of African descent and Indigenous Peoples.

10. A decolonial approach to drug use, harm reduction and the right to health must examine the underlying power structures that perpetuate the systems of disadvantage that have outlived colonialism, shaping the underlying dynamics of both drug use and how States address it. Whether related to access to treatment, health care, harm reduction or access to controlled medicines, States must ensure that all drug control measures are human rights-compliant. Taking an anti-coloniality and anti-racist approach, the Special Rapporteur explores how criminalization and stigmatization can be a legacy of colonialism and structural discrimination, negatively affecting the right to health and creating the need for a substantive equality approach to drug laws and policies, including those rooted in harm reduction.

II. Methodology

11. In the present report, the Special Rapporteur builds on the work of her predecessors, who have analysed the human rights impacts of international drug laws and policies under the "war on drugs", and specifically how these legal frameworks have contributed to an environment of increased human rights risks and violations.¹³ The Special Rapporteur wishes to focus on harm reduction alternatives as transformative tools in the intersection of health and human rights.

12. In various communications, the Special Rapporteur has identified people who use drugs as a population frequently living in vulnerable and marginalized circumstances.¹⁴

¹¹ WHO, "Commercial determinants of health", 21 March 2023.

¹² Rebecca Haffajee and Michelle M. Mello, "Drug companies' liability for the opioid epidemic", *The New England Journal of Medicine*, vol. 377, No. 24 (December 2017), pp. 2301–2305.

¹³ See A/65/255; and OHCHR, "Statement by the UN expert on the right to health on the protection of people who use drugs during the COVID-19 pandemic", 16 April 2020.

¹⁴ See communications SGP 1/2022, SGP 3/2021, SGP 2/2022, SGP 4/2022 and LKA 2/2023. Available at <https://spcommreports.ohchr.org/Tmsearch/TMDocuments>.

13. The concept of harm reduction has been primarily developed in the context of drug use and refers to policies, programmes and practices that are aimed at minimizing the negative health, social and legal impacts associated with drug use, drug policies and drug laws.¹⁵ It includes needle and syringe programmes, supervised injection and drug use facilities, opioid substitution therapy, overdose prevention and community outreach programmes, as well as access to legal assistance, social services, housing and adequate food.¹⁶

14. In preparing the present report, the Special Rapporteur issued a call for inputs,¹⁷ inviting stakeholders to share their lived experiences and knowledge of relevant laws, policies and practices, which she aimed to reflect in the report, with a particular focus on the individuals and communities who have long been made most vulnerable. She expresses her appreciation to all who contributed.

III. Legal framework

15. Everyone is entitled to the highest attainable standard of physical and mental health, with no discrimination (arts. 2 (2) and 12 of the International Covenant on Economic, Social and Cultural Rights). The right to health is also provided for in several other international human rights instruments,¹⁸ including the International Convention on the Elimination of All Forms of Racial Discrimination (art. 5 (e) (iv)) and the International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families (arts. 28 and 43).

16. Article 12 (2) (c) and (d) of the International Covenant on Economic, Social and Cultural Rights covers the prevention, treatment and control of diseases, which include drug use disorder,¹⁹ and the creation of conditions that ensure medical care when needed. Article 15 (1) (b) of the Covenant states that everyone has the right to enjoy the benefits of scientific progress and its applications. That right has been recognized as being instrumental to the realization of the right to health²⁰ and applies in the context of drug use disorder and in the development of laws and policies aimed at addressing drug use more generally.

17. Every person is entitled to, among other things, access to timely and appropriate health care, including health facilities, goods and services that are available, accessible, acceptable and of quality, without discrimination.²¹ Furthermore, the right to health extends beyond health care to the underlying determinants of health, including access to health-related education and information, housing, healthy occupational and environmental conditions, and participation in health-related decision-making at the community, national and international levels.²² In the context of drug use, it is key to both address the underlying determinants of health and adopt an intersectional equality and non-discrimination approach.

18. The right to health also includes sexual and reproductive health.²³ The Special Rapporteur reiterates that sexual and reproductive rights are also grounded in the right to life, to dignity, to education and information, to equality before the law and non-discrimination; the right to decide on the number and spacing of children; the right to privacy; the right to health; the right to freedom of opinion and expression; the right to consent to marriage and equality in marriage; and the right to be free from gender-based violence, harmful practices

¹⁵ Harm Reduction International, "What is harm reduction?", available at <https://hri.global/what-is-harm-reduction/>.

¹⁶ Harm Reduction International, *The Global State of Harm Reduction 2020*, 7th ed. (London, 2020).

¹⁷ See <https://www.ohchr.org/en/calls-for-input/2023/drug-policies-and-responses-right-health-framework-harm-reduction>.

¹⁸ A/HRC/53/65, para. 14.

¹⁹ A/65/255, para. 55.

²⁰ Committee on Economic, Social and Cultural Rights, general comment No. 25 (2020), para. 67.

²¹ Committee on Economic, Social and Cultural Rights, general comment No. 14 (2000), paras. 11 and 12. See also Committee on Economic, Social and Cultural Rights, general comment No. 20 (2009), paras. 7 and 8 (a) and (b).

²² Committee on Economic, Social and Cultural Rights, general comment No. 14 (2000), para. 11.

²³ A/76/172, para. 18.

and torture and ill-treatment; as well as the right to an effective remedy for violations of fundamental rights.²⁴ The Special Rapporteur stresses that sexual and reproductive health encompasses, among others, maternal health care, safe abortion care and the prevention, diagnosis and treatment of infertility, reproductive cancers, sexually transmitted infections and HIV/AIDS, including with generic medicines.²⁵

19. The right to health comprises both freedoms and entitlements²⁶ and is interconnected with economic, social, cultural, civil and political rights. In this regard, other human rights such as the right to life²⁷ and the right to information are relevant in the context of drug policies, both as a component of the right to health²⁸ and as a standalone right.²⁹ In some instances, people who use drugs are forcibly committed to treatment facilities in violation of their right to give informed consent for treatment.³⁰ Closely related to the right to information is the right to privacy.³¹ While the accessibility of information includes the right to seek, receive and impart information and ideas concerning health issues, the exercise of this right should not impair the confidentiality of personal health data.³²

20. Article 6 of the International Covenant on Civil and Political Rights stresses that States have a heightened duty of care to take any necessary measures to protect the lives of individuals deprived of their liberty by the State.³³ In their duty to protect life, States should also take appropriate measures to address the general conditions in society, which may include the prevalence of life-threatening diseases.

21. Everyone has the right to be free from non-consensual medical treatment and informed consent is required prior to the administration of medical treatment. Everyone also has the right to have personal health data treated with confidentiality.³⁴ In the context of drug use, evidence-based harm reduction options, such as needle and syringe programmes and the prescription of substitute medicines, should be available on a voluntary basis to all people with drug use disorders, including persons deprived of their liberty, in accordance with the rights to health, non-discrimination and equality.³⁵

22. The international drug control regime consists of three core treaties. The first is the Single Convention on Narcotic Drugs of 1961 as amended by the 1972 Protocol, which consolidated previous international agreements, brought specific plants under international control (e.g. marijuana, coca and opium poppy), created a regulatory system for the medical and scientific uses of those plants and established the International Narcotics Control Board. The second is the Convention on Psychotropic Substances of 1971, which established an international control system for psychoactive drugs such as amphetamine-type stimulants, barbiturates, benzodiazepines and psychedelics. The third is the United Nations Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances of 1988, in which it was recognized that previous international efforts had not been able to prevent the illicit drug trade and connections were drawn with organized crime to justify the increased policing of drugs worldwide. Together, these three treaties put hundreds of drugs under international control and criminalized virtually every aspect of the unauthorized production and distribution thereof.³⁶ The original aim of the treaties was to protect the health and welfare of

²⁴ [A/76/172](#), para. 18.

²⁵ *Ibid.*, para. 20.

²⁶ Committee on Economic, Social and Cultural Rights, general comment No. 14 (2000), para. 8.

²⁷ See Human Rights Committee, general comment No. 36 (2018).

²⁸ Committee on Economic, Social and Cultural Rights, general comment No. 14 (2000), para. 12 (b).

²⁹ International Covenant on Civil and Political Rights, art. 19 (2).

³⁰ [A/HRC/10/44](#), paras. 65 and 71; see also [A/64/272](#).

³¹ Committee on Economic, Social and Cultural Rights, general comment No. 14 (2000), para. 3.

³² *Ibid.*, para. 12 (b) (iv); and [A/HRC/53/65](#), paras. 19 and 22.

³³ Human Rights Committee, general comment No. 36 (2018), para. 25.

³⁴ Committee on Economic, Social and Cultural Rights, general comment No. 14 (2000), paras. 8 and 12; see also [A/64/272](#).

³⁵ [A/65/255](#), para. 55.

³⁶ [A/65/255](#), para. 9. See also the 1961 Convention as amended, art. 36 (“each Party shall adopt such measures as will ensure that cultivation, production, manufacture, extraction, preparation, possession, offering, offering for sale, distribution, purchase, sale, delivery on any terms whatsoever, brokerage,

humankind. However, current drug control policies have primarily taken a punitive approach to suppress the market in illicit drugs, and many countries have adopted repressive policies, with consequent impacts on human rights.³⁷ The International Narcotics Control Board has urged all Governments to consistently apply internationally recognized human rights principles and protections when designing and implementing drug control policies and has emphasized the importance of ensuring sufficient availability of controlled substances at the global level to ensure access to and the availability of substances for the treatment of pain. It has also called upon all States to develop mechanisms to improve the collection of information on drug use prevalence, with the aim of developing drug use prevention and treatment strategies that are based on evidence and tailored to each country's specific needs.³⁸ Furthermore, it has called upon States to shift efforts from compulsory and involuntary treatment services for people who use drugs towards alternatives to imprisonment and punishment in drug treatment and rehabilitation.³⁹

23. While the treaties under the international drug control framework do not explicitly mention or consider implications for human rights, Member States and United Nations bodies have declared that international drug control must be carried out in conformity with the Charter of the United Nations and respect for human rights.⁴⁰ The human rights framework further applies in the context of drugs, as discussed above. In its resolution 52/24, the Human Rights Council recognized the need for States to take steps to ensure access to health-related information, evidence-based prevention, harm reduction and treatment and to address the underlying social and economic determinants of health, in the context of the world drug problem. Also in that resolution, the Council reaffirmed the commitment made by the General Assembly to respecting, protecting and promoting all human rights, fundamental freedoms and the inherent dignity of all individuals.

24. In its resolution 78/131, the General Assembly called upon States to improve access to controlled substances for medical and scientific purposes by appropriately addressing existing barriers in this regard, including those related to legislation, regulatory systems, health-care systems, affordability, the training of health-care professionals and education.

25. The Special Rapporteur welcomes the adoption, in March 2024, of resolution 67/4 by the Commission on Narcotic Drugs, in which the Commission encouraged States to explore harm reduction measures aimed at preventing and minimizing the adverse public health and social consequences of the non-medical use of drugs. She acknowledges the International Commission of Jurists 8 March Principles for a Human Rights-Based Approach to Criminal Law Proscribing Conduct Associated with Sex, Reproduction, Drug Use, HIV, Homelessness and Poverty, in particular principle 20, on drug use and possession, purchase or cultivation of drugs for personal use.

State obligations

26. States have an obligation to respect, protect and fulfil human rights. In the context of drug use, the obligation to respect requires that States not engage in any conduct that can result in drug use-related morbidity or mortality. This includes refraining from marketing unsafe drugs and from applying coercive medical treatments, except under exceptional

dispatch, dispatch in transit, transport, importation and exportation of drugs contrary to the provisions of this Convention ... shall be punishable offences when committed intentionally").

³⁷ A/HRC/54/53, para. 3.

³⁸ *Report of the International Narcotics Control Board for 2021* (E/INCB/2021/1), pp. 125–127.

³⁹ *Report of the International Narcotics Control Board for 2023* (E/INCB/2023/1), p. 135.

⁴⁰ Outcome document of the thirtieth special session of the General Assembly, entitled "Our joint commitment to effectively addressing and countering the world drug problem"; Ministerial Declaration on Strengthening Our Actions at the National, Regional and International Levels to Accelerate the Implementation of Our Joint Commitments to Address and Counter the World Drug Problem; high-level declaration by the Commission on Narcotic Drugs on the 2024 midterm review, following up to the Ministerial Declaration of 2019; and Commission on Narcotic Drugs resolutions 49/4, 51/12 and 53/9.

circumstances – subject to specific and restrictive conditions – for the treatment of mental illness or the prevention and control of communicable diseases.⁴¹

27. The obligation to protect requires States to, among other actions, adopt legislation or take other measures ensuring equal access to health care and health-related services provided by third parties⁴² and ensuring that scientific knowledge and technologies and their applications – including evidence-based interventions to prevent and treat drug dependence, in addition to related diseases – are available and accessible without discrimination. States have an obligation to implement evidence-based interventions to minimize the adverse health and risks and harms associated with drug use.⁴³ This obligation also requires States to take measures to prevent third parties from interfering with the enjoyment of human rights and to ensure effective protection against rights violations linked to business activities and access to effective remedies for victims of such corporate abuses.⁴⁴

28. The obligation to fulfil requires States, for instance, to promote the right to health by undertaking actions that create, maintain and restore the health of the population. This obligation includes fostering the recognition of factors favouring positive health results, such as research and the provision of information and ensuring that health-care providers are trained to recognize and respond, with culturally acceptable services, to the specific needs of vulnerable or marginalized groups.⁴⁵ Such groups include people who use drugs, who face different and intersectional forms of vulnerability.

29. While some obligations may be realized progressively due to resource constraints, others, such as the principle of non-discrimination, must be implemented immediately. The core obligations of States include the provision of essential drugs, as defined under the World Health Organization (WHO) Action Programme on essential drugs.⁴⁶

30. Establishing prohibited grounds of discrimination requires a multipronged approach. First, drug use disorders are a prohibited ground of discrimination under the International Covenant on Economic, Social and Cultural Rights.⁴⁷ Second, both drug use and drug use disorders may qualify as a prohibited ground of discrimination, considering that persons who use drugs and persons with drug use disorders have long suffered and continue to suffer stigmatization and marginalization,⁴⁸ and people who use drugs must not be unjustifiably denied access to health-care services on the basis of their prior or current drug use status.⁴⁹ Third, drug laws and policies have had disparate impacts on protected groups, also discussed below, resulting in indirect discrimination.⁵⁰ Importantly, some of the individuals who suffer the disparate impacts of drug laws and policies experience intersecting layers of discrimination.⁵¹ Thus, substantive equality, or the realization of what it will take for those individuals who have been made most vulnerable in society to thrive,⁵² requires the dismantling of the different systems of oppression that underpin both direct and indirect discrimination in the context of drug use, in particular when drug laws and policies have themselves been instrumental in perpetuating such systems of oppression.⁵³

⁴¹ Committee on Economic, Social and Cultural Rights, general comment No. 14 (2000), paras. 33 and 34.

⁴² Ibid., para. 33.

⁴³ [A/65/255](#), para. 55. See also International Centre on Human Rights and Drug Policy and others, “International guidelines on human rights and drug policy” (2019).

⁴⁴ Committee on Economic, Social and Cultural Rights, general comment No. 24 (2017), para. 14.

⁴⁵ Committee on Economic, Social and Cultural Rights, general comment No. 14 (2000), paras. 33, 36 and 37.

⁴⁶ Committee on Economic, Social and Cultural Rights, general comment No. 14 (2000), para. 43 (d).

⁴⁷ Committee on Economic, Social and Cultural Rights, general comment No. 20 (2009), para. 33.

⁴⁸ Ibid., para. 27.

⁴⁹ [A/65/255](#), para. 23.

⁵⁰ Committee on Economic, Social and Cultural Rights, general comment No. 20 (2009), para. 10 (b).

⁵¹ Ibid., para. 17.

⁵² See also [A/78/185](#).

⁵³ See Michelle Alexander, *The New Jim Crow: Mass Incarceration in the Age of Colourblindness* (London, Penguin Books, 2019).

IV. Criminalization, stigmatization and health

31. The intersection of criminal law, health, and human rights is multifaceted. The failure to adopt a human-rights based approach to addressing drug use has had negative impacts on the health of both individuals and populations. In this regard, the stigmatization and criminalization of drug use represent a barrier for people with drug use disorders to accessing services, establishing therapeutic relationships and continuing treatment regimes, leading to poorer health outcomes as, in addition to stigmatization, they may fear legal consequences or harassment and judgment.⁵⁴

32. The discriminatory application of criminal law must be tackled at every stage, including by reforming drug-related laws, policies and practices with discriminatory outcomes, in line with international human rights norms and standards.⁵⁵ Where people who use drugs are discriminated against in health-care facilities, they may be deterred from seeking health-care services, which in turn increases their vulnerability to other infectious diseases, such as HIV, and also affects the delivery of treatment programmes.⁵⁶ Violations of privacy and confidentiality of health records dissuade people who use drugs from seeking health-care services. This is particularly so in circumstances where medical records are shared with law enforcement agencies, leading to criminalization.⁵⁷

33. While punitive drug laws are often enacted and enforced in the name of medicine, public health and public order, the widespread use of criminal law, as well as the “war on drugs” and the pursuit of a “drug-free world”, has failed to deter drug use or prevent related harms. Moreover, the international drug control regime has added to harms at both the individual and the societal levels through its detrimental consequences.

34. States are under an obligation to respect the right to health by, among others, refraining from denying or limiting equal access for all persons, including prisoners or detainees, to curative and palliative health services.⁵⁸ Persons who are deprived of their liberty are equally entitled to the right to health, and those who use drugs are particularly vulnerable when deprived of their liberty in facilities that have inadequate health-care services.⁵⁹ The obligation to respect the right to health includes providing persons deprived of their liberty with the necessary medical care and appropriate regular monitoring of their health and to refrain from denying or limiting their equal access to preventive, curative and palliative health-care services.⁶⁰ Furthermore, all persons deprived of their liberty must be treated with dignity and humanity, which includes persons deprived of their liberty for drug-related crimes. The Special Rapporteur stresses that an approach aimed at increasing access to evidence-based and voluntary treatment is most effective in reducing drug use and the social harm caused and is also in compliance with the international drug control conventions.

35. Within prison settings, high rates of drug use by injection, a lack of access to harm reduction services and a lack of prevention and treatment services lead to a high prevalence of HIV, hepatitis C and tuberculosis.⁶¹ Many prisons fail to provide appropriate medical care,

⁵⁴ [A/HRC/14/20](#), para. 47.

⁵⁵ [A/HRC/47/53](#), para. 42.

⁵⁶ [A/HRC/10/44](#), paras. 58 and 59.

⁵⁷ [A/64/272](#), para. 20. See also Open Society Institute, “The effects of drug user registration laws on people’s rights and health: key findings from Russia, Georgia, and Ukraine” (New York, 2009), pp. 16–18.

⁵⁸ Committee on Economic, Social and Cultural Rights, general comment No. 14 (2000), para. 34.

⁵⁹ [A/HRC/10/44](#), para. 57.

⁶⁰ Human Rights Committee, general comment No. 36 (2018), para. 25. See also the United Nations Standard Minimum Rules for the Treatment of Prisoners (the Nelson Mandela Rules). Rule 24 establishes that health care for prisoners is a State responsibility. See also [A/HRC/38/36](#), paras. 18, 34 and 98 (a).

⁶¹ Kate Dolan and others, “Global burden of HIV, viral hepatitis, and tuberculosis in prisoners and detainees”, *The Lancet*, vol. 388, No. 10049 (2016); European Centre for Disease Prevention and Control and European Monitoring Centre for Drugs and Drug Addiction, “Systematic review on active case finding of communicable diseases in prison settings” (Stockholm, 2017); and Penal Reform International, “Health in prisons: realising the right to health”, Penal Reform Briefing, No. 2

including evidence-based treatment for drug use disorders, or deny people who use drugs the opportunity to provide informed consent before being tested or treated.⁶² In this regard, the Committee against Torture has recommended ensuring the provision of medical services to prisoners, in particular those with drug use disorders, and taking all measures necessary to implement the United Nations Standard Minimum Rules for the Treatment of Prisoners (the Nelson Mandela Rules).⁶³ In addition to the Nelson Mandela Rules, the United Nations Rules for the Treatment of Women Prisoners and Non-custodial Measures for Women Offenders (the Bangkok Rules) and the United Nations Standard Minimum Rules for the Administration of Juvenile Justice (the Beijing Rules) are applicable to women and children, respectively, deprived of their liberty.⁶⁴

36. Being charged with a drug-related offence is a stigma that can last a lifetime, creating impediments to employment, education, travel, immigration, custody of children, privacy and freedom from discrimination,⁶⁵ as well as to the enjoyment of civil and political rights such as the right to vote⁶⁶ and the rights to participation, freedom of association and peaceful assembly and freedom of opinion, expression and information.

V. Impact of drug laws and policies on persons from marginalized groups of the population

37. Historic and ongoing racism, discrimination and power asymmetries contribute significantly to constructing vulnerable situations.⁶⁷ Current drug laws and policies have had a profoundly negative impact on minorities, women and girls, LGBTIQ+ persons, sex workers, migrants and people living with HIV/AIDS, among other groups of the population. In many cases, punitive drug regimes intersect with the other forms of criminalization and stigmatization to which certain individuals are subjected. The circumstances of those individuals underpin their relationships with drug use and may create a barrier to receiving appropriate care in case of drug use disorders.

38. Women who use drugs face higher levels of social stigma and discrimination, and harm reduction services are often designed without accounting for gendered differences.⁶⁸ Women who use drugs are also subject to rates of violence that are up to 24 times higher than those experienced by women who do not use drugs. This highlights the need to integrate harm reduction services with those for gender-based violence and sexual and reproductive health.⁶⁹

39. LGBTIQ+ persons who use drugs may not seek support or treatment from health-care providers because of previous or anticipated experiences of discrimination. They are disproportionately affected by drug policies in many countries, and experience harms.⁷⁰ Despite some progress in recent years, there remains heavy stigma and taboo surrounding sexualized drug use, including “chemsex” (sexual activity under the influence of drugs), which is most common among men who have sex with men.⁷¹ Stigma and discrimination have contributed to persistent gaps in research, a lack of programmes to address the needs of

(2007), available at https://cdn.penalreform.org/wp-content/uploads/2013/06/brf-02-2007-health-in-prisons-en_01.pdf.

⁶² A/65/255, paras. 29 and 59–61. See also Harm Reduction International, *The Global State of Harm Reduction 2022*, 8th ed. (London, 2022).

⁶³ CAT/C/CPV/CO/1, paras. 25 and 25 (e).

⁶⁴ See also https://www.unodc.org/res/justice-and-prison-reform/nelsonmandelarules-GoF/UN_System_Common_Position_on_Incarceration.pdf.

⁶⁵ Aliza Cohen and others, “How the war on drugs impacts social determinants of health beyond the criminal legal system”, *Annals of Medicine*, vol. 54, No. 1 (2022), pp. 2024–2038.

⁶⁶ See Alexander, *The New Jim Crow*.

⁶⁷ See A/HRC/47/28.

⁶⁸ Women and Harm Reduction International Network, “Women who use drugs: intersecting injustice and opportunity” (2022).

⁶⁹ United Nations Office on Drugs and Crime, *Addressing Gender-Based Violence against Women and People of Diverse Gender Identity and Expression who use Drugs* (Vienna, 2023).

⁷⁰ A/HRC/39/39, para. 76.

⁷¹ Hannah McCall and others, “What is chemsex and why does it matter?”, *BMJ*, vol. 351, No. 8032 (November 2015).

this population, ongoing barriers to access the services that do exist and lack of action at the policy level to protect the health of LGBTIQ+ persons who use drugs.

40. People who use drugs and also engage in sex work face similar and often overlapping challenges, including stigma, exposure to health risks such as violence, and the denial of health services.⁷² Law enforcement officials are often guided by harmful stereotypes of what a sex worker or person who uses drugs “looks like”; such stereotypes are grounded in racism and discrimination based on class, sex and gender that cause racial and ethnic minorities, women and LGBTIQ+ persons to be far more likely to be stopped, searched, arrested and charged if drugs or drug paraphernalia are found.⁷³ Sex workers who use drugs are often the target of violence by clients, the public or law enforcement officials, but are unlikely to report violence or seek redress given their fear of criminalization. Further, even when harm reduction services are available, sex workers who use drugs are often treated as solely “sex workers” or “drug users”, and their specific and intersecting needs are not met.⁷⁴

41. Laws prohibiting drug use and possession are often-used pathways and justification for apprehending and deporting migrants and other non-citizens.⁷⁵ The physical and mental trauma that migrants experience along their journeys when fleeing unbearable conditions may also contribute to drug use, and potentially drug use disorders, in particular when alternative forms of care to address said trauma are inaccessible.⁷⁶ What can result is double criminalization, for both migration status and drug use.

42. About 1 in 10 new HIV infections result from drug use by injection, yet criminal laws relating to HIV and drug use impede access to HIV prevention and treatment.⁷⁷ Against the recommendation of international human rights bodies,⁷⁸ over 92 countries have criminal laws relating to HIV and other sexually transmitted infections, including laws that criminalize HIV transmission, actions that can potentially expose another person to HIV and non-disclosure of HIV status.⁷⁹ General criminal laws can also be used to criminalize the actions of people with HIV – including breastfeeding mothers.⁸⁰ Thus, it is no surprise that people living with HIV and using drugs are driven away from the appropriate and evidenced-based health care that they might need.

43. Considering that civilian infrastructure usually collapses in conflict situations, the availability of controlled medicines is severely hampered by conflict. For both conflict and non-conflict emergency situations, it is recognized in both the outcome document of the thirtieth special session of the General Assembly, entitled “Our joint commitment to effectively addressing and countering the world drug problem”, and the “International guidelines on human rights and drug policy” that access to controlled medicines without discrimination is a key element of the right to health, including anaesthesia during medical procedures and for the treatment and management of various health conditions.

⁷² Global Network of Sex Work Projects, “Sex workers who use drugs” (2015). See also <https://www.ohchr.org/sites/default/files/2024-03/2024-march-sex-work-guide-un-report-short.pdf>.

⁷³ Jenny Iversen and others, “Patterns and epidemiology of illicit drug use among sex workers globally: a systematic review”, in *Sex Work, Health, and Human Rights: Global Inequities, Challenges, and Opportunities for Action*, Shira M. Goldenberg and others, eds. (Springer, 2021).

⁷⁴ Global Network of Sex Work Projects, “Sex workers who use drugs”.

⁷⁵ Sarah Tosh, “Drug prohibition and the criminalization of immigrants: the compounding of drug war disparities in the United States deportation regime”, *International Journal of Drug Policy*, vol. 87 (January 2021).

⁷⁶ *World Drug Report 2023* (United Nations publication, 2023), booklet 2, pp. 99–114.

⁷⁷ WHO, “People who inject drugs”, available at <https://www.who.int/teams/global-hiv-hepatitis-and-stis-programmes/populations/people-who-inject-drugs>.

⁷⁸ See A/HRC/14/20.

⁷⁹ Joint United Nations Programme on HIV/AIDS (UNAIDS), *Prevailing against Pandemics by Putting People at the Centre* (Geneva, 2020), p. 60.

⁸⁰ Alison Symington, “When law and science part ways: the criminalization of breastfeeding by women living with HIV”, *Therapeutic Advances in Infectious Disease*, vol. 9 (January–December 2022).

VI. Prevention, treatment and control of diseases

44. The requirement to prevent, treat and control diseases encompasses the establishment of prevention and education programmes for behaviour-related health concerns and the creation of a system of urgent medical care in cases of epidemics, accidents and similar health hazards.⁸¹ Interventions such as educational programmes empower people who use drugs to make informed decisions relating to their health and minimize the potential harms related to drug use. This can be done through outreach programmes through which people who use drugs are engaged in their own communities and provided with information, referrals for medical testing and services, and empowered to respond to overdoses through first-aid training such as in the administration of naloxone.⁸²

45. The mandatory testing of children for drug use in educational settings as a preventive measure raises human rights concerns. Under articles 3 and 16 of the Convention on the Rights of the Child, taking children's bodily fluids without their consent may be inconsistent with the principle of the best interests of the child and may violate the right to bodily integrity and constitute arbitrary interference with privacy and dignity. Depending on how such testing is carried out, it could also constitute degrading treatment.⁸³

46. The requirements of informed consent must be observed in administering any treatment, regardless of whether it is drug use-related, and include the right to refuse treatment.⁸⁴ Access to information is also relevant to the right to prevention, treatment and control of epidemic, endemic and other diseases, requiring the establishment of prevention and education programmes for behaviour-related health concerns,⁸⁵ including in relation to drug use and drug use disorders.

VII. Commercial determinants of health and the opioid crisis

47. The pharmaceutical industry has a decisive impact on the realization of the right to health and in relation to decision-making power over what medicines and types of diseases it researches and invests in. Harmful practices of pharmaceutical companies that undermine access to medicines and the right to health, such as corporate pressure within the framework of the regulatory, oversight and judicial functions of the State, as well as economic incentives to doctors to prescribe certain medicines,⁸⁶ are relevant to the responses to drug use.

Access to controlled medicines

48. Barriers to improving access to controlled substances for medical and scientific purposes are related to legislation, regulatory systems, health-care systems, affordability, the training of health-care professionals, education, awareness-raising, estimates, assessment and reporting, benchmarks for consumption of substances under international control, and international cooperation and coordination.⁸⁷ In its resolution 63/3, the Commission on Narcotic Drugs called for the promotion of 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. In the high-level declaration by the Commission on Narcotic Drugs on the 2024 midterm review, following up to the Ministerial Declaration of 2019, Member States reiterated their resolve to ensure access to and the availability of

⁸¹ Committee on Economic, Social and Cultural Rights, general comment No. 14 (2000), para. 16.

⁸² [A/65/255](#), paras. 53 and 54.

⁸³ [A/HRC/39/39](#), para. 8.

⁸⁴ [A/64/272](#), paras. 28 and 88–91.

⁸⁵ Committee on Economic, Social and Cultural Rights, general comment No. 14 (2000), para. 16.

⁸⁶ Inter-American Commission on Human Rights, *Business and Human Rights: Inter-American Standards* (2019), paras. 223 and 224.

⁸⁷ Outcome document of the thirtieth special session of the General Assembly, entitled “Our joint commitment to effectively addressing and countering the world drug problem”, para. 2; and Commission on Narcotic Drugs resolution 62/5.

controlled substances for medical and scientific purposes, including for the relief of pain and suffering, and to address existing barriers in that regard.

49. Despite international commitments, statistics show that 17 per cent of the global amount of morphine used for pain relief is consumed in low- and middle-income countries. The regions with the lowest rates of consumption of narcotic drugs for medical purposes in the world are Africa, Central America and the Caribbean, South Asia, and East and South-East Asia.⁸⁸

50. All people rely on essential controlled medicines for pain, opioid dependence, palliative care and other health conditions.⁸⁹ The right to health includes a core, minimum obligation to provide access to essential medicines,⁹⁰ which, under the WHO Model List of Essential Medicines, include morphine, methadone and buprenorphine. These and other substances are also listed under the international drug control conventions, despite the 1961 Convention as amended explicitly recognizing that the medical use of narcotic drugs continues to be indispensable for the relief of pain and suffering and that adequate provision must be made to ensure the availability of narcotic drugs for such purposes. Medications listed under these treaties are often restricted excessively.

51. Further, given the discrimination surrounding perceptions of pain and who “deserves” relief, the populations most often denied access to controlled medicines include people who are pregnant or postpartum and people with underlying health conditions.⁹¹

52. The failure to ensure access to essential medicines for pain relief and drug use disorders threatens the realization of the rights to health and to freedom from cruel, inhumane and degrading treatment.⁹²

53. The Special Rapporteur notes recent developments in which medicines related to fertility management have become the subject of court proceedings in some jurisdictions, with the aim of limiting access to such evidence-based medicines for the management of medical abortion. Although not in the present report, the Special Rapporteur will pay attention to these developments and advise on the trends of using the law to cause harm in the practice of medicine by unfairly limiting essential medicines, contrary to WHO guidelines,⁹³ in spheres of medicine other than those related to drug use.

VIII. Harm reduction policies for public health

54. The criminalization, overuse of incarceration, arbitrary deprivation of life, unnecessary use of lethal force in drug enforcement and application of the death penalty as punishment in the name of public health have resulted in various human rights violations. Human rights violations deriving from drug use criminalization have had negative effects on public health through unintended consequences. In contrast, when well designed and implemented, drug laws and policies – including in harm reduction – can protect and promote public health while contributing to the realization of human rights in a mutually reinforcing way.⁹⁴

55. The criminalization of drug use and possession of drugs for personal use can pose a threat to health and well-being. Once people have a conviction for a drug-related offence, they may face considerable obstacles in obtaining employment and may lose access to government benefits, such as basic income assistance, student loans, public housing and food

⁸⁸ See <https://unis.unvienna.org/unis/en/pressrels/2022/unisnar1463.html>.

⁸⁹ “International guidelines on human rights and drug policy”.

⁹⁰ Committee on Economic, Social and Cultural Rights, general comment No. 14 (2000), para. 43 (d).

⁹¹ Jamila K. Taylor, “Structural racism and maternal health among black women”, *The Journal of Law, Medicine & Ethics*, vol. 48, No. 3 (September 2020).

⁹² A/HRC/22/53, para. 56.

⁹³ See https://cdn.who.int/media/docs/default-source/reproductive-health/abortion/summary-chart-medical-management-abortion.pdf?sfvrsn=c735d28a_4.

⁹⁴ Jonathan M. Mann and others, “Health and human rights”, *Health and Human Rights Journal*, vol. 1, No. 1 (fall 1994), pp. 6–23 (arguing that the promotion and protection of rights and health are inextricably linked).

assistance, or may face difficulties travelling abroad. The criminalization of possession and personal use of drugs often also results in disproportionate sentencing, in addition to hindering persons in need of treatment for drug use from receiving such treatment.⁹⁵ The criminalization of drug use also aggravates the stigmatization of and discrimination against people who use drugs.⁹⁶

56. Criminalization is but a single – and extreme – option within a regulatory spectrum.⁹⁷ Regulatory frameworks need to be cohesively developed by States in a way that is more or less restrictive depending on scientific evidence⁹⁸ and considering power asymmetries (e.g. major corporations’ influence on policymaking).⁹⁹ For instance, regulation models may consider whether permitting and regulating access would reduce overall harms, exploring to what extent, by what means and to whom specific drugs should be restricted within a jurisdiction.

IX. Harm reduction policy tools

57. Decriminalizing drug use is the removal of criminal penalties for drug offences, including for but not limited to use or possession, and is a way of reducing the negative impacts of punitive drug policy on the right to health. Evidence from jurisdictions that have taken a decriminalization approach demonstrates that adopting less punitive policies does not result in an increase in drug use, drug-related harms or other crimes.¹⁰⁰

58. Divesting from the “war on drugs” can also free up resources to reinvest in health and harm reduction services – creating a pathway for an approach grounded in public health and human rights that is also based on the best available scientific evidence.¹⁰¹

59. Harm reduction includes a wide range of policies, programmes and practices that are aimed at minimizing the negative health, social and legal impacts associated with drug use and drug laws and policies.¹⁰² As harm reduction measures work best when they are available to people in their current circumstances, it is important that they are modified and tailored to the intersecting needs of the individual.¹⁰³

60. The following paragraphs contain a non-exhaustive list of practical harm reduction measures that numerous States have begun to implement.

61. **Needle and syringe programmes.** These programmes provide access to and disposal of sterile injection equipment, often along with other services such as vaccination, testing and infectious disease care and treatment for drug use disorders. At least 92 countries have needle and syringe exchange programmes.¹⁰⁴

62. **Opioid agonist therapy.** Opioid agonists such as methadone and buprenorphine are therapeutic drugs that are used for the management of opioid dependence. There is a strong

⁹⁵ See [A/HRC/30/65](#), [A/HRC/39/39](#) and [E/C.12/PHL/CO/5-6](#).

⁹⁶ UNAIDS, *Health, Rights and Drugs: Harm Reduction, Decriminalization and Zero Discrimination for People Who Use Drugs* (Geneva, 2019), p. 33.

⁹⁷ Lawrence O. Gostin and Lindsay F. Wiley, *Public Health Law: Power, Duty, Restraint* (Oakland, California, University of California Press, 2016), p. 199.

⁹⁸ [A/65/255](#), para. 73.

⁹⁹ Radhika Gore and Richard Parker, “Analysing power and politics in health policies and systems”, *Global Public Health*, vol. 14, No. 4 (2019), pp. 481–488.

¹⁰⁰ Drug Policy Alliance, “Approaches to decriminalizing drug use & possession”, February 2015; “Drug decriminalisation: grounding policy in evidence”, *The Lancet*, vol. 402, No. 10416 (2023); and Corey S. Davis and others, “Changes in arrests following decriminalization of low-level drug possession in Oregon and Washington”, *International Journal of Drug Policy*, vol. 119, September 2023.

¹⁰¹ Harm Reduction International, “Aid for the war on drugs” (London, 2023).

¹⁰² Harm Reduction International, “What is harm reduction?”.

¹⁰³ National Harm Reduction Coalition, “Principles of harm reduction”, available at <https://harmreduction.org/about-us/principles-of-harm-reduction/>.

¹⁰⁴ Harm Reduction International, “What is harm reduction?”.

evidence base supporting their effectiveness.¹⁰⁵ WHO includes these drugs on its Model List of Essential Medicines and recommends opioid agonist therapy as a treatment option for opioid dependence, along with psychosocial treatment and support.¹⁰⁶ As of 2022, 88 countries offered opioid agonist therapy, meaning that it is still highly inaccessible in many parts of the world.¹⁰⁷ Additional barriers to opioid agonist therapy include identification requirements, in-person distribution requirements, drug testing requirements and distance to treatment facilities, along with the stigma associated with seeking treatment for drug dependence, the cost of both the treatment itself and the additional costs, and distrust, in particular among racial and ethnic minorities. These highlight the need for culturally tailored and community-led therapy options.¹⁰⁸

63. **Drug consumption rooms and supervised injection facilities.** These sites provide a place where people who inject drugs can self-administer their own substances without criminal penalties, under hygienic conditions and under the supervision of qualified personnel, such as harm reduction workers, social workers, nurses and other medical professionals. With the first authorized site established in Switzerland in the 1980s, over 100 drug consumption rooms now operate in over 17 countries – with many more likely operating “underground”.¹⁰⁹ Where drug use is still a criminal offence, the police, prosecutors and other law enforcement officials can develop policies of excluding individuals who obtain services from drug consumption facilities from prosecution. For example, the Lord Advocate of Scotland indicated that she would be prepared to publish a prosecution policy in relation to a pilot safer drugs consumption facility.¹¹⁰

64. **Drug checking.** Drug checking is a practice for providing people who use drugs with information on the chemical composition of the drugs in their possession to facilitate more informed decision-making. It includes mobile and fixed services where samples can be dropped off or posted, with the analysis then provided to the individuals. These help prevent fatal overdoses and help collect data on trends in the unregulated drug supply.¹¹¹

65. **Overdose prevention and reversal.** Naloxone is a life-saving medication that can be used to reverse an overdose of opioids, including prescription opioids, heroin and fentanyl, when administered in a timely manner. It blocks the effects of opioids and restores normal breathing within minutes. WHO deems naloxone essential and recommends that it be made available to people likely to witness an opioid overdose. It also recommends training in the management of opioid overdose.¹¹² Nearly 40 per cent of opioid overdose deaths occur in the presence of another person; the availability of naloxone can thus allow bystanders to stop a fatal overdose and save a significant number of lives.¹¹³ People on a low income, people living in rural areas and Black communities have disproportionately low access to naloxone. Legal changes can help increase access to naloxone, such as requiring insurers to cover naloxone, easing or removing prescription requirements to enable anyone to carry naloxone,

¹⁰⁵ National Academies of Sciences, Engineering, and Medicine, *Medications for Opioid Use Disorder Save Lives* (Washington, D.C., National Academies Press, 2019), chap. 2.

¹⁰⁶ WHO, “Opioid overdose”, 29 August 2023, available at <https://www.who.int/news-room/fact-sheets/detail/opioid-overdose>.

¹⁰⁷ Harm Reduction International, “What is harm reduction?”.

¹⁰⁸ The Network for Public Health Law, “A cross-sector approach to removing legal and policy barriers to opioid agonist treatment”, December 2020.

¹⁰⁹ Harm Reduction International, “What is harm reduction?”.

¹¹⁰ Scotland, Crown Office & Procurator Fiscal Service, “Statement on pilot safer drug consumption facility”, 11 September 2023.

¹¹¹ Nazlee Maghsoudi and others, “Drug checking services for people who use drugs: a systematic review”, *Addiction*, vol. 117, No. 3 (March 2022), pp. 532–544.

¹¹² WHO, “Community management of opioid overdose” (Geneva, 2014), available at <https://www.who.int/publications/i/item/opioid-overdose-preventing-and-reducing-opioid-overdose-mortality>.

¹¹³ Julie O’Donnell and others, “Vital signs: characteristics of drug overdose deaths involving opioids and stimulants – 24 states and the District of Columbia, January–June 2019”, *Morbidity and Mortality Weekly Report*, vol. 69, No. 35 (September 2020), pp. 1189–1197.

creating naloxone training opportunities and increasing legal protections under Good Samaritan laws for those who administer naloxone.¹¹⁴

66. **Housing, employment and education.** Underlying determinants of health should not be conditional on the discontinuation or reduction of drug use, or maintained through mandated or compulsory tests. While the root causes of drug use and drug use disorder are multifaceted, research has shown that the deterioration of social and economic well-being is associated with increases in overdose deaths – often referred to as “deaths of despair”.¹¹⁵ In addition, legal services and legal training for people who use drugs can assist with access to housing, health and social services and awareness of rights and when those rights are being violated.¹¹⁶

67. At the domestic and international levels, funding for harm reduction is inadequate and shrinking.¹¹⁷ Reportedly, only \$131 million is currently available for harm reduction in low- and middle-income countries and less than 7 per cent of international donor funding for harm reduction is given to community-led harm reduction organizations.¹¹⁸ There is a 95 per cent funding gap for harm reduction in low- and middle-income countries.¹¹⁹

X. Good practices

68. The Special Rapporteur expresses her appreciation for the extensive and detailed responses to her call for submissions, including information on good practices on harm reduction, notably through partnerships between peer-led community organizations and national authorities.

69. In Kenya in 2012, in response to a growing prevalence of HIV among people who inject drugs, the Government shifted its approach to address drug use by injection as a public health issue. Consequently, the country currently has more than 10 public opioid agonist therapy programmes and 35 drop-in centres with needle-syringe programmes, as well as take-home naloxone, pre-exposure prophylaxis and HIV self-testing services. There are also community-based programmes specifically geared towards women who inject drugs.¹²⁰

70. In Brazil in 2021, the FRESH Project was launched in São Paulo with the support of the Joint United Nations Programme on HIV/AIDS (UNAIDS) to engage transgender women in harm reduction programming, focusing on pre-exposure prophylaxis, post-exposure prophylaxis and harm reduction. The FRESH project uses photographic art to emphasize self-worth and self-care as part of the pathway to collective change.¹²¹

71. In Australia, naloxone is available to take home for free, without the need for a prescription, to people who may experience or witness an opioid overdose or adverse reaction, thereby reducing harms. The country’s Mindframe programme provides guidance to the media on communicating safely, respectfully and responsibly about drugs and alcohol,

¹¹⁴ Rafael E. Pérez-Figueroa, Carrie B. Oser and Kasia Malinowska, “Access to naloxone in underserved communities”, *BMJ*, vol. 381 (April 2023).

¹¹⁵ Elisabet Beseran and others, “Deaths of despair: a scoping review on the social determinants of drug overdose, alcohol-related liver disease and suicide”, *International Journal of Environmental Research and Public Health*, vol. 19, No. 19 (2022).

¹¹⁶ Joanne Csete and Jonathan Cohen, “Health benefits of legal services for criminalized populations: the case of people who use drugs, sex workers and sexual and gender minorities”, *Journal of Law, Medicine, and Ethics*, vol. 38, No. 4 (2010), pp. 816–831.

¹¹⁷ Harm Reduction International, “Failure to fund: the continued crisis for harm reduction funding in low- and middle-income countries” (London, 2021).

¹¹⁸ Harm Reduction International, “Funding for harm reduction”, available at <https://hri.global/topics/funding-for-harm-reduction/#>.

¹¹⁹ Harm Reduction International, “Tracking funding for harm reduction”, available at <https://hri.global/topics/funding-for-harm-reduction/tracking-funding-for-harm-reduction/>.

¹²⁰ Submission from UNAIDS.

¹²¹ UNAIDS, “Unboxing self-esteem among transgender women in Brazil and their dreams for a dignified life”, 17 May 2022, available at <https://www.unaids.org/en/keywords/brazil>.

recognizing that inaccurate and dehumanizing language plays a significant role in the process of stigmatization.¹²²

72. In Austria, Suchthilfe Wien is conducting a study examining the feasibility of opioid agonist therapy by injection with hydromorphone, in particular for a subset of patients for whom traditional opioid agonist medications are ineffective.¹²³

73. In September 2023, the Croatian Institute of Public Health joined the European Syringe Collection and Analysis Project Enterprise network and has been piloting the analysis of the residual content of used syringes, based on more than 200 samples collected in the city of Split. The project seeks to complement existing data on substances injected by people who use drugs by providing timely and local information.¹²⁴

74. In September 2023, Colombia announced a policy that explicitly recognizes international human rights and drug policy guidelines. Within its borders, it has made significant changes to domestic drug policies.¹²⁵

75. In Czechia, a mobile drug consumption room was launched in September 2023 and a project focusing on testing drug samples at dance events has been under way since 2020.¹²⁶ Similarly, in Ireland in May 2022, the Safer Nightlife Programme was launched. Under the programme, information is distributed concerning drug trends and activities are undertaken that are aimed at influencing behaviour and encouraging safer choices.¹²⁷

76. The Society for Positive Atmosphere and Related Support to HIV and AIDS (SPARSHA) in Nepal focuses on providing harm reduction services for people living with HIV and has opened a specific drop-in centre for women, serving almost 200 women. AIDS Community Care Montreal in Canada runs a programme called Kontak, which is a harm reduction programme by and for gay, bisexual and queer men who have sex with men, with a special focus on people who use drugs during sex.¹²⁸

77. In New York, community organizations have supported overdose prevention centres located in the neighbourhoods of Harlem and the Bronx. Operated by a group called OnPoint, they serve the population, most of whom are Black or Latino and are on a low income, in areas with the highest rates of overdose death in the city. The centres have reversed more than 1,000 overdoses and operate under a “wellness model” that also provides showers, laundry, a respite room, mental health services and connections to other care.¹²⁹

78. During the period 2022–2023, with the support of the United Nations Entity for Gender Equality and the Empowerment of Women (UN-Women), the national network of women living with HIV in Indonesia contributed to the development of the provincial special operating procedures for the Government’s response to cases of violence against women to ensure that the process is responsive to the priorities of women living with and affected by HIV, including those who use drugs.¹³⁰

79. Since 2019, six countries (Barbados, Dominica, Kyrgyzstan, Luxembourg, Malta and Trinidad and Tobago) have decriminalized drug use and the possession of drugs for personal use at the domestic level, either for all drugs or for some substances in particular. Such decriminalization has also been introduced in nine jurisdictions at the federal level, namely: the Australian Capital Territory; British Columbia, Canada; and Hawaii, Illinois, New Jersey, New Mexico, New York, Oregon and Virginia, United States of America. This brings the

¹²² Submissions from Australia and Harm Reduction Australia.

¹²³ Submission from Austria.

¹²⁴ Submission from Croatia.

¹²⁵ Volker Türk, United Nations High Commissioner for Human Rights, statement at the high-level side event during the sixty-seventh session of the Commission on Narcotic Drugs, 14 March 2024, available at <https://www.ohchr.org/en/statements-and-speeches/2024/03/war-drugs-has-failed-says-high-commissioner>.

¹²⁶ Submission from Czechia.

¹²⁷ Submission from Ireland.

¹²⁸ Submission from Harm Reduction International.

¹²⁹ Submission from the Open Society Foundations.

¹³⁰ Submission from UN-Women.

total number of jurisdictions having adopted some form of decriminalization to 66, in 40 countries.¹³¹

XI. Conclusions and recommendations

80. The Special Rapporteur underlines the need for States to move from a reliance on criminal law and instead take a human rights-based, evidence-based and compassionate approach to harm reduction in relation to drug use and drug use disorders.

81. Discriminatory practices and requirements that limit eligibility for welfare assistance for people with a drug use record or involve requirements for drug testing of anyone with a prior drug conviction or suspected of drug use perpetuate social instability and poor health outcomes.

82. People who use drugs, in particular those who have been historically marginalized and criminalized, should be meaningfully involved in the development and design of drug laws and policies, including harm reduction policies and services.

83. States are obliged to develop national health legislation and policies, and to strengthen their national health systems and budgets.

84. Harm reduction services such as needle exchange programmes and opioid substitution treatment should be implemented in order to realize the right to health and the right to benefit from scientific progress and its applications.¹³²

85. On the basis of the principles of equality and non-discrimination, transparency, participation and accountability, the Special Rapporteur recommends that States:

(a) Urgently ratify the International Covenant on Economic, Social and Cultural Rights, while paying attention to immediate interventions and the longer-term social transformation required, so as to recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health;

(b) Urgently and comprehensively examine the legal frameworks governing drug control for their impact on public health and human rights, in particular on populations that have been historically disadvantaged and that have borne a disproportionate harm;

(c) Decriminalize, repeal, rescind or amend laws and policies that have a negative impact on the right to health and that perpetuate different systems of oppression, such as racism and colonialism;

(d) Approach evidence-based harm reduction as conducive to the realization of the right to health and health-related rights. As part of their obligations to guarantee the right to health, States must ensure that harm reduction services are in line with the operationalization of the right to health approach, namely that services are available, acceptable, accessible and of quality. The provision of services must be non-discriminatory in law and in practice;

(e) Comply with human rights law and standards and remove barriers to harm reduction services, including through the distribution of harm reduction information, facilities, services and goods through various means of outreach, including mail-order distribution, mobile and in-person services, automated dispensing machines and direct delivery. Such services and goods should be available in spaces and during times when people are using drugs;

(f) Decriminalize the use, possession, purchase and cultivation of drugs for personal use and move toward alternative regulatory approaches that put the protection of people's health and other human rights front and centre. Responsible

¹³¹ International Drug Policy Consortium, *Off Track: Shadow Report for the Midterm Review of the 2019 Ministerial Declaration on Drugs* (2023).

¹³² E/C.12/MUS/CO/4, para. 27; and E/C.12/EST/CO/2, para. 26.

regulatory frameworks would then need to be cohesively developed by States that are informed by scientific evidence (e.g. the risks associated with each drug and their possible mitigation, capacity to establish and enforce adequate regulations for that drug) and taking into account power asymmetries (e.g. major corporations' influence on policymaking);

(g) Call upon private actors to respect human rights, as indicated in the Guiding Principles on Business and Human Rights;

(h) Ensure that peer-led initiatives remain at the forefront, with political and policy support and stable and sufficient resourcing and funding;

(i) Support the training and continuous education of health-care professionals that is necessary to ensure the "do no harm" principle;

(j) Partner with peer-led initiatives to collect comprehensive data and help guarantee equal access to harm reduction services and programmes in a non-discriminatory and non-stigmatizing way, considering in particular the needs of the most vulnerable and marginalized groups, such as Black and Indigenous populations, minorities, LGBTIQ+ persons, migrants, sex workers and women;

(k) Fund programmes to challenge prevalent stigmas surrounding drug use and programmes to enhance providers' competency in providing non-discriminatory services to people who use drugs. Where possible, harm reduction, such as home delivery of opioid agonist therapy medication, offering dosing at community pharmacies and distributing opioid agonist therapy in outreach settings, should be combined with other forms of care (e.g. mental health and social services);

(l) Design harm reduction services so that they provide suitable environments for women who use drugs, including by providing integrated sexual and reproductive health care, information and services, and childcare;

(m) Ensure that drug control policies do not impede access to essential medicines, including but not limited to those required for palliative care and pain management (including for children) and harm reduction (e.g. methadone and buprenorphine), for any populations or medical need such as abortion care, paying particular attention to populations that have faced marginalization and overpolicing in the context of drugs;

(n) Ensure that drug law enforcement does not lead to violations of the enjoyment of the right to health, paying particular attention to the disproportionate impact that drug laws, policies and policing have had on marginalized groups and people who face multiple and intersecting forms of discrimination, including women and girls, Black persons, racial and ethnic minorities, Indigenous Peoples, children and young people, people living in poverty, sex workers, migrants and LGBTIQ+ persons;

(o) Desist from law enforcement practices that hamper the right to health, including the seizure or destruction of injection equipment and the prosecution of health-care and harm reduction service providers;

(p) Ensure that law enforcement agencies do not target health facilities, supervised drug consumption rooms or needle and syringe programmes as a strategy for drug law enforcement;

(q) Encourage employers to end the widespread use of drug testing in employment decisions, which has documented racial disparities, considering the lack of evidence to support a causal connection between drug testing and improved safety or productivity;

(r) Protect against undue influence over policymaking by anti-rights groups and powerful private industries, including the pharmaceutical industry and the private prison industry, whose interests may conflict with the enjoyment of the highest attainable standard of health for all;

(s) Collect disaggregated data and statistics on drug-related matters, with adequate safeguards for privacy and confidentiality, to inform policymaking in an efficient and effective manner;

(t) Recognize the cultural and medicinal uses of plants and flora for their rich diversity beyond western medical paradigms by protecting the rights of Black people, Indigenous Peoples and people of African descent to grow, access and use such plants and flora without extraction and depletion by industries;

(u) Revise the international legal framework on drug control to best align with international human rights norms and standards, harm reduction approaches and the operationalization of the right to health approach (that services are available, acceptable, accessible and of quality), facilitating drug laws and policies at the domestic level to be centred on dignity, public health and human rights, as well as grounded in the best available evidence, free from conflicts of interest;

(v) End criminalization, stigmatization and discrimination, as they represent structural barriers to accessing services and establishing therapeutic relationships, leading to poorer health outcomes as people may fear legal consequences. This will improve trust, dialogue, creativity and innovation in this urgent moment of a paradigm shift;

(w) Put global advocacy and high-level statements of intent into action to uphold the right to dignity. The realization of the right to the highest attainable standard of physical and mental health of people who use drugs, people with drug use disorders and people whose health and well-being is affected by drug laws and policies must be respected, promoted and fulfilled in the move towards substantive equality.
