



Report to the Office of the High Commissioner for Human Rights

Implementation of the UNGASS joint commitment to effectively addressing and countering the world drug problem with regard to human rights

18 May 2018

Harm Reduction International welcomes the opportunity to consult on the implementation of the joint commitment to effectively addressing and countering the world drug problem with regard to human rights, and to contribute to the report of the Office of the High Commissioner for Human Rights

Harm Reduction International is a leading non-governmental organisation working to reduce the negative health, social and human rights impacts of drug use and drug policy by promoting evidence-based public health policies and practices, and human rights based approaches to drug policy. Our vision is a world in which individuals and communities benefit from drug laws, policies and practices that promote health, dignity and human rights.

This submission will focus on the implementation of the joint commitment to effectively addressing and countering the world drug problem, adopted as the outcome of the 2016 United Nations General Assembly Special Session on the world drug problem (hereafter: UNGASS Outcome Document) with focus on Paragraphs 1(m) and 1(o) (under Operational recommendations on demand reduction and related measures, including prevention and treatment, as well as other health-related issues) and Paragraphs 4 (a), (b), (c), (g), (m), and (n) (under Operational recommendations on cross-cutting issues: drugs and human rights, youth, children, women and communities).

Background

Human rights and drug control have existed, for decades, in “parallel universes.”¹ This resulted in repressive policies and practices for the control of drugs which lead to, or enable, a wide range of human rights violations and abuses worldwide, disproportionately impacting upon the most vulnerable in society and perpetuating cycles of violence and marginalisation, while failing to substantially reduce drug-related harms and risks.

Human rights and drug control are closely intertwined, and a comprehensive system of human rights standards exists that should guide State actions with respect to drug control and people who use drugs, and in the interpretation of the three UN Drug Control Conventions.

The UNGASS Outcome Document represents a key milestone in the acknowledgment of the interactions between drug control and human rights. Human rights were authoritatively sanctioned as a fundamental reference in the design and implementation of drug control policies, with States being urged to “ensure that national drug policies [...] fully respect human rights and fundamental freedoms.”² Also, for the first time in a high-level UN document,³ the General Assembly explicitly endorsed a number of harm reduction interventions.

Implementation of commitments related to the right to health (Paragraphs 4(a) and (b)), with respect to elements for the prevention and treatment of overdose (Paragraph 1 (m)) and measures aimed at minimizing the adverse public health and social consequences of drug abuse (Paragraph 1 (o))

The right to the highest attainable standard of health requires all States to provide, as a matter of priority, national, comprehensive harm reduction services for people who use drugs.⁴

Availability of harm reduction services and interventions

According to Larney et al, less than 1% of all persons who inject drugs live in countries with high coverage of both needle and syringe programmes (NSP) and opioid substitution therapy (OST).⁵ Governments worldwide are failing to implement adequate and integrated harm reduction interventions, ignoring a strong body of evidence of its effectiveness.

In the [Global State of Harm Reduction 2016](#), Harm Reduction International reported that, although injecting drug use is documented in at least 158 countries and territories, OST is not in place in 78 countries, while 68 states have failed to introduce NSP.⁶

This failure to adopt and implement adequate harm reduction strategies is in tension with human rights obligations that require states that ratified the International Covenant on Economic, Social and Cultural Rights

¹ Paul Hunt, ‘Human rights, health, and harm reduction – States’ amnesia and parallel universes’ (keynote presentation at the 19th International Harm Reduction Conference, Barcelona, Spain, May 11, 2008). Accessible at: <https://www.hri.global/files/2010/06/16/HumanRightsHealthAndHarmReduction.pdf>

² UNGASS Outcome Document, Paragraph 4(a)

³ Gen Sander, ‘The global state of harm reduction in prisons: Inadequate, unreliable and unlawful’ (Penal Reform International, 6 February 2017). Available at <https://www.penalreform.org/blog/the-global-state-of-harm-reduction-in-prisons/>

⁴ Paul Hunt, ‘Human rights, health, and harm reduction’, 8. Key human rights mechanisms have reiterated this principle, such as: Special Rapporteur on the right of everyone to the highest attainable standard of mental and physical health, Dainius Pūras, ‘Open Letter in the context of the preparations for the UN General Assembly Special Session on the Drug Problem (UNGASS), which will take place in New York in April 2016’ (7 December 2015)

⁵ Sarah Larney et al., “Global, regional, and country-level coverage of interventions to prevent and manage HIV and hepatitis C among people who inject drugs: a systematic review” 5(12) *The Lancet* (December 2017)

⁶ Katie Stone (ed.), ‘The Global State of Harm Reduction 2016’ (London: Harm Reduction International, 2016), 9

(ICESCR)⁷ to progressively realize the right to the health, substantially restricting their discretion to adopt retrogressive measures;⁸ while at the same time also jeopardizing the achievement of Sustainable Development Goal 3 ('Good health and wellbeing').

There have been pockets of progress in scaling up responses to the prevention and treatment of overdose. One key example is the introduction of new Supervised Injection Facilities (also known as Drug Consumption Rooms) – key to the prevention and treatment of overdose, with authorities expressing their support for this interventions in a growing number of countries.⁹ By 2017, ten countries were operating these facilities, although none of them in Africa, Asia, Central and Latin America.¹⁰

A spike in overdose deaths in North America, and to a lesser extent the United Kingdom, prompted the implementation of naloxone overdose prevention programmes, both for the general population and for individuals in detention.¹¹ Evidence of best practices can be seen in Australia¹² and Scotland; here, a National Naloxone Programme is being implemented envisaging the distribution of take-home kits from community outlets and prisons.¹³ A similar initiative has been rolled out in the state of New York (USA), and has been found to be “relevant and empowering.”¹⁴ However, overall availability of naloxone worldwide is still insufficient, with some countries – such as South Africa – currently experiencing a stock-out of this essential opioid antagonist.¹⁵

Accessibility, affordability and quality of harm reduction interventions

States that ratified ICESCR have an obligation to take steps to progressively realize the right to health to the maximum of their available resources,¹⁶ including through international cooperation. Additionally, core components of the right to health are the accessibility, affordability, and quality of health goods and services.¹⁷ Despite this, recent research by Harm Reduction International, focused on the European Union, revealed a concerning decline in the funding of harm reduction services by the part of both governments and international donors,¹⁸ with a detrimental impact on individual as well as public health.¹⁹

⁷ UN General Assembly, *International Covenant on Economic, Social and Cultural Rights*, 16 December 1966, United Nations, Treaty Series, Vol. 993

⁸ International Covenant on Economic, Social and Cultural Rights, Articles 2.1 and 12

⁹ Among others, see: 'France's first drug room for addicts to inject opens in Paris' (BBC News, 11 October 2016). Available at: <http://www.bbc.co.uk/news/world-europe-37617360>; Ingrid Torjesen, 'Scottish MPs urge UK government to allow drug consumption rooms to be piloted in Scotland' (The Pharmaceutical Journal, 22 January 2018). Available at: scotland/20204264.article; William Neuman, 'De Blasio moves to bring safe injection sites to New York City' (New York Times, 3 May 2018). Available at: <https://www.nytimes.com/2018/05/03/nyregion/nyc-safe-injection-sites-heroin.html> /

¹⁰ Vendula belackova et al., 'Online Census of Drug Consumption Rooms (DCRs) as a setting to address HCV: current practice and future capacity' (Amsterdam, Sidney: International Network of Drug Consumption Rooms, 2018). Accessible at: <http://www.drugconsumptionroom-international.org/index.php/dcr-survey/dcr-survey-2017>

¹¹ Katie Stone (ed.), 'The Global State of Harm Reduction 2016' (London: Harm Reduction International, 2016), 19

¹² Robin Dwyer et al., "An overview of take-home naloxone programs in Australia" 37(4) *Drug and Alcohol Review* (May 2018). Accessible at: <https://onlinelibrary.wiley.com/doi/abs/10.1111/dar.12812>

¹³ For an overview and evaluation of the program, see: 'National Naloxone Programme Scotland. Monitoring Report 2016/17' (NHS National Services Scotland, Information Services Division, 2017). Accessible at: <http://www.sdf.org.uk/wp-content/uploads/2017/11/2017-11-07-Naloxone-Report.pdf>

¹⁴ Vedan Anthony-North et al., 'Correction-Based Responses to the Opioid Epidemic: Lessons from New York State's Overdose Education and Naloxone Distribution Program' (New York: Vera Institute of Justice, 2018). Accessible at: https://storage.googleapis.com/vera-web-assets/downloads/Publications/corrections-responses-to-opioid-epidemic-new-york-state/legacy_downloads/corrections-responses-to-opioid-epidemic-new-york-state.pdf

¹⁵ Scheibe A, Shelly S, Mac Donnell J. Global State of Harm Reduction survey response 2018 (London: Harm Reduction International, 2018)

¹⁶ International Covenant on Economic, Social and Cultural Rights, Article 2.1

¹⁷ OHCHR and WHO, 'Fact Sheet No.31: The Right to Health' (Geneva, 2008), 4. Accessible at: <http://www.ohchr.org/Documents/Publications/Factsheet31.pdf>

¹⁸ Catherine Cook, 'Harm Reduction Investment in the European Union' (London: Harm Reduction International, 2017)

¹⁹ Among others, see the example of Romania. Catherine Cook, 'Harm Reduction Investment in the European Union' (London: Harm Reduction International, 2017), 17

From the obligation to progressively realise fundamental rights to the maximum of available resources, is the obligation that states allocate their budget effectively. Notwithstanding this, human rights mechanisms have observed how drug policies too often detract essential resources from the public health sector.²⁰

Implementation of commitments related to States' obligation to ensure non-discriminatory access to health, care and social services in prevention, primary care and treatment programmes, including in detention settings (Paragraphs 4 (b) and (m)), to prevent acts of cruel, inhuman or degrading treatment (Paragraph 4 (c)) and to mainstream a gender perspective (Paragraphs 4 (g) and (n))

Non-discrimination is another core component of the right to health.²¹ However, people who use drugs continue to face significant obstacles in accessing health services, with certain categories experiencing a particularly acute level of discrimination.

Gender mainstreaming in the design, implementation, and provision of health services

Women and girls confront unique barriers in accessing treatment programmes tailored to their needs and experiences,²² both in and out of prison, where harm reduction services are often either absent or designed primarily for male prisoners, while appropriate mental health support is too often unavailable.²³

In addition, drug offences (especially minor, non-violent ones) are among the main drivers of the surge in the rates of incarceration of women around the globe²⁴ – especially women belonging to ethnic minorities and indigenous women.²⁵ This trend has also been captured in reports by human rights bodies. For example, in September 2017 the Committee on the Elimination of Racial Discrimination identified drug policies as one of the leading causes of the high rate of incarceration of indigenous peoples and minorities in Canada;²⁶ a few months prior to this, the Committee on the Elimination of Discrimination Against Women expressed concerns about the “excessive use of incarceration as a drug-control measure against women and the ensuing female overpopulation in prison in the country.”²⁷

Equivalence of care for individuals in detention

As emphasised by the General Assembly in the UNGASS Outcome Document,²⁸ individuals in detention retain their fundamental right to health, and States have a heightened, positive obligation to protect those most vulnerable, and/or under their direct control. In addition, evidence shows that harm reduction interventions can

²⁰ Among others, see: UN Human Rights Council. Report of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment, Manfred Nowak: Promotion and Protection of all Human Rights, Civil, Political, Economic, Social and Cultural Rights, Including the Right to Development (14 January 2009), para 50. UN Doc. A/HRC/10/44

²¹ Committee on Economic, Social and Cultural Rights. General Comment no.20: on-discrimination in economic, social and cultural rights (2 July 2009). UN Doc. E/C.12/GC/20

²² Among others, see: Kasia Malinowska-Sempruch and Olga Rychkova, 'The Impact of Drug Policy on Women (New York: Open Society Foundation, 2015). Accessible at: <https://www.opensocietyfoundations.org/sites/default/files/impact-drug-policy-women-20160928.pdf>

²³ Emily van der Meulen, “A Legacy of Harm: Punitive Drug Policies and Women’s Carceral Experiences in Canada” 28(2) *Women & Criminal Justice* (April 2017). Accessible at: <https://www.tandfonline.com/doi/full/10.1080/08974454.2017.1307160>

²⁴ Andrew Coyle, Catherine Heard and Helen Fair, “Current trends and practices in the use of imprisonment” 98(3) *International Review of the Red Cross* (2016), 766. Accessible at: <https://www.icrc.org/en/international-review/detention-addressing-human-cost>

²⁵ Among others, see Emily van der Meulen, “A Legacy of Harm: Punitive Drug Policies and Women’s Carceral Experiences in Canada” 28(2) *Women & Criminal Justice* (April 2017), 81

²⁶ Committee on the Elimination of Racial Discrimination. Concluding observations on the combined twenty-first to twenty-third periodic reports of Canada (13 September 2017), para. 15. UN Doc. CERD/C/CAN/CO/21-23

²⁷ Committee on the Elimination of Discrimination against Women. Concluding observations on the combined eighth and ninth periodic reports of Canada (25 October 2016), para. 44. UN Doc. CEDAW/C/CAN/CO/8-9

²⁸ Outcome Document, paragraphs 1(o), 4(b), 4(m)

be implemented safely and effectively in prison settings,²⁹ where they are greatly needed. Indeed, the prevalence of HIV, hepatitis C virus (HCV) and tuberculosis (TB) is still considerably higher among prison population than in the general population,³⁰ and detention settings are “high-risk environments for the transmission of these diseases.”³¹ Additionally, it was estimated that 57.9% of people who inject drugs globally has a history of incarceration.³² As a consequence, effective and high-quality treatment options for persons with drug dependence should be available in prisons, in the same measure and of the same quality as those provided to the general public,³³ and in such a way that responds to the specific needs of the prospective beneficiaries.

However, lack of political will and financial support results in a dearth of these fundamental services in many detention settings. At the end of 2016, OST was only available to some degree in 52 countries,³⁴ while only 8 countries (all in Western Europe and Central Asia) provided NSPs in at least one prison;³⁵ in May 2018, Canada announced the implementation of a Needle Exchange Program in two detention institutions.³⁶ Although these data show an increase from 2014, substantial issues remain; for example, even when available these services are often of an inferior quality than those provided outside detention settings, their accessibility is limited, and continuity of treatment for persons who arrive in prison, are transferred, or are released is far from guaranteed.³⁷ Among others, the European Committee for the Prevention of Torture has urged States to adopt comprehensive and multi-faceted plans and practices for the treatment of drug addiction in detention, also ensuring continuity of treatment started before the admission in prison.³⁸ Harm Reduction International has repeatedly urged national authorities as well as international mechanisms to integrate an analysis of the availability of adequate harm reduction services in detention in their assessments of States’ compliance with their human rights obligations. At this end, we also developed a human-rights based tool for the monitoring of HIV, HCV and TB and harm reduction in prisons.³⁹

Denying treatment to a person with a drug dependence can cause the person unbearable pain and suffering. It is now recognised by human rights mechanisms that the denial of treatment services to prisoners with a drug

²⁹ Gen Sander and Fionnuala Murphy, “The Furthest Left Behind: The Urgent Need to Scale Up Harm Reduction in Prisons” 13(3/4) *International Journal of Prisoner Health* (2017), 185

³⁰ Gen Sander, ‘Monitoring HIV, HCV, TB and Harm Reduction in Prisons: a Human Rights-Based Tool to Prevent Ill Treatment’ (London: Harm Reduction International, 2016), 7

³¹ Gen Sander, ‘Monitoring HIV, HCV, TB and Harm Reduction in Prisons: a Human Rights-Based Tool to Prevent Ill Treatment’, 7

³² Degenhardt et al., “Global prevalence of injecting drug use and sociodemographic characteristics and prevalence of HIV, HBV, and HCV in people who inject drugs: a multistage systematic review” 5 *Lancet Global Health* (December 2017), 1203

³³ Among others, see: General Assembly. Resolution 70/175: United Nations Standard Minimum Rules for the Treatment of Prisoners (8 January 2016), Rule 24. UN Doc. A/RES/70/175

³⁴ Katie Stone (ed.), ‘The Global State of Harm Reduction 2016’ (London: Harm Reduction International, 2016), 19

³⁵ For an updated overview of the availability of NSP in prisons in Europe, see Bielen et al., “Harm reduction and viral hepatitis C in European prisons: a cross-sectional survey of 25 countries” *Harm Reduction Journal* (2018), 19

³⁶ “Correctional Service Canada announces a Prison Needle Exchange Program” (Correctional Service Canada, 2018). Available at <https://www.canada.ca/en/correctional-service/news/2018/05/correctional-service-canada-announces-a-prison-needle-exchange-program.html>

³⁷ Gen Sander and Fionnuala Murphy, “The Furthest Left Behind: The Urgent Need to Scale Up Harm Reduction in Prisons” 13(3/4) *International Journal of Prisoner Health* (2017), 187

³⁸ European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment, ‘26th General Report of the CPT: 1 January – 31 December 2016’ (Council of Europe, 2017), para. 73. Doc. CPT/Inf (2017) 5. Accessible at: <https://rm.coe.int/168070af7a>; Council of Europe, ‘Report to the Bulgarian Government on the visit to Bulgaria carried out by the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT) from 25 September to 6 October 2017’ (4 May 2018), para. 97. Accessible at: <https://rm.coe.int/16807c4b74>; Council of Europe, Report to the Lithuanian Government on the visit to Lithuania carried out by the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT) from 5 to 15 September 2016’ (1 February 2018), para. 74. Doc. CPT/Inf (2018) 2. Accessible at: <https://rm.coe.int/pdf/16807843ca>

³⁹ Gen Sander, ‘Monitoring HIV, HCV, TB and Harm Reduction in Prisons: a Human Rights-Based Tool to Prevent Ill Treatment’ (London: Harm Reduction International, 2016)

dependence can constitute inhuman or degrading treatment.⁴⁰ The European Court of Human Rights reiterated this principle in September 2016, when it concluded that the failure by German authorities to adequately assess the need for opioid substitution therapy of an opioid dependent prisoner, and the physical and mental suffering this caused, amounted to inhuman treatment.⁴¹

Conclusion

In light of these findings, Harm Reduction International invites the Office of the High Commissioner for Human Rights to urge States to:

- Ensure nation-wide availability of accessible, affordable, adequate and high-quality harm reduction goods, services and interventions to people who use drugs; emphasising a rights-based approach to service delivery, which upholds the dignity, autonomy and agency of individuals;
- Implement safe, effective, and evidence-based policies and practices for the prevention and treatment of drug-related harms and risks, placing particular attention to the needs and experiences of women, individuals in detention, and other vulnerable groups;
- Adopt and implement adequate strategies for the monitoring and evaluation of HIV, HCV and TB and harm reduction in prisons from a human-rights perspective;
- Review budgetary allocations in such a way that reflects an understanding of drugs as a public health - rather than a criminal justice - concern, and address non-compliance with States' obligations to progressively realise the right to the highest attainable standard of health to the maximum of their available resources;
- Prevent and combat any form of discrimination against people who use drugs in the access to health goods and services, as well as in the design and implementation of drug control and criminal justice policies and interventions.

⁴⁰ Human Rights Council. Report of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment, Juan E. Méndez (1 February 2013), para. 54. UN Doc A/HRC/22/53; Human Rights Committee. Concluding observations on the seventh periodic report of the Russian Federation (28 April 2015), para. 16. UN Doc. CCPR/C/RUS/CO/7

⁴¹ European Court of Human Rights *Wenner v. Germany* App. 62303/13 (1 September 2016)