



TAKING STOCK: A DECADE OF DRUG POLICY

A CIVIL SOCIETY SHADOW REPORT



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Taking stock: A decade of drug policy

Foreword

Global drug control policies have been based on the general principles of eliminating the production, trade or use of any illegal psychoactive substance from the world. Yet policies which seek to reach that objective have involved harsh law-enforcement and even militarisation. These end up affecting the most vulnerable people who use drugs, subsistence farmers involved in illegal crop cultivation and small-scale traffickers because they are easier to apprehend than are wealthy and well-connected people. The collateral damages are human rights and lives – those of the most vulnerable and those of the voiceless. To quote the Deputy High Commissioner for Human Rights (May 2018), in a world that is meant to be more inclusive and where no one should be left behind, ‘people who use drugs are not left behind. They are left outside.’

A decade ago, the international community reiterated its aspiration to achieve a drug-free world. Yet over that decade, available data shows that the production, sale, and consumption of currently illegal drugs are soaring. So are the harms related to current policies, with dramatic increases in overdoses, prison overcrowding, HIV and hepatitis transmission, a more revenue-generating and increasingly violent illegal market, and in the condoning by some of extrajudicial killings against people who use drugs – killings that often take place in broad daylight.

Ten years after the world’s governments adopted at the UN the Political Declaration and Plan of Action on drugs, there is still little discussion on how to evaluate the impact of current policies, or on how to analyse the results of the policies implemented during this period. In 2014, there was a mid-term High-Level Review of the Political Declaration and Plan of Action. It resulted in a new negotiated document that reiterated the commitments, without providing any such ‘High-Level Review’. Two years later, the 2016 UNGASS on drugs provided another opportunity to review the current approach, to no avail. Although progress was made in bringing in more visibility to issues related to health, human rights and development, the resulting Outcome Document failed to recognise the harmful consequences of the war on drugs approach.

The international community is meeting again at a Ministerial Segment at the Commission on Narcotic Drugs in March 2019 to decide upon a common



Rt Hon Helen Clark

Credit: Global Commission on Drug Policy

strategy for the next ten years. But how can we plan the future without a serious and far-ranging assessment of the past’s errors and successes? How can we quantify the unintended consequences of drug control policies when they are not evaluated? Up until now, no comprehensive evaluation has been carried out either on progress towards achieving the 2009 targets or on the consequences of the past decade in global drug control on human rights, health, security, development, the environment, and on the lives of the millions of affected people worldwide.

Furthermore, there is little appetite among countries for such a review from the UN, proving once more that drug policy remains mostly an ideological issue rather than a societal topic that needs to be addressed based on evidence, dialogue, and building consensus. In that vacuum, I welcome this Civil Society Shadow Report in which the International Drug Policy Consortium which provides us with an excellent overview of the progress and the lack of it made in the last decade, as well as highlighting the challenges and opportunities ahead – using all existing government-based and UN-based data, along with scientific and grey literature.

What we learn from the shadow report is compelling. Since governments started collecting data on drugs in the 1990s – based on the seizures of illegal substances, on the arrests of people who use drugs and their admission to treatment services, and on the eradication of illegal crops – the cultivation, consumption and illegal trafficking of

drugs have reached record levels. Moreover, current drug policies are a serious obstacle to other social and economic objectives: progress on combating the HIV epidemic had been significant in the last 20 years, but is now stalled among people who inject drugs; prison overcrowding has worsened, with a fifth of the world's inmates being arrested for drug-related offences and mostly for drug use alone; and the 'war on drugs' has resulted in millions of people murdered, disappeared, or internally displaced. As the situation stands today, the major Sustainable Development Goals that concern gender equality, the protection of the environment, socioeconomic development, and the reduction of violence and corruption will not be achieved for an important part of the population because of current drug policies.

But there is still hope for a better outcome and for the international community to do better during the 2019 high-level meeting. While the possibility of building a new negotiated political declaration and plan of action is unlikely with the lack of any monitoring and assessment apart from the current Shadow Report, the Vienna-based consensus that

has driven countries to agree on the paths to control drugs is breaking, both at the multilateral and at the regional levels.

It is our hope, at the Global Commission on Drug Policy, that the next decade in global drug policy will align with the 2030 Agenda for Sustainable Development to alleviate the pain and suffering of millions of people affected by current drug policies, with the objective of leaving no one behind. By providing the most comprehensive assessment of the past lost decade, I am certain that this Civil Society Shadow Report will greatly contribute to the global drug control debates and ensure that the coming decade will be better embedded in the international community's priorities of human rights, development, peace and security.

Rt Hon Helen Clark

Member of the Global Commission on Drug Policy

Former Prime Minister of New Zealand, 1999-2008

Former Administrator of the United Nations Development Programme, 2009-2017

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Abbreviations

AIDS	Acquired Immune Deficiency Syndrome
ARQ	Annual Report Questionnaire
ATS	Amphetamine Type Stimulants
CARICOM	Caribbean Community
CCPCJ	Commission on Crime Prevention and Criminal Justice
CICAD	Inter-American Drug Abuse Control Commission
CND	Commission on Narcotic Drugs
COPOLAD	Cooperation Programme between Latin America, the Caribbean and the European Union on Drug Policies
ECDD	Expert Committee on Drug Dependence
EU	European Union
FARC	Revolutionary Armed Forces of Colombia
FATF	Financial Action Task Force
GDP	Gross Domestic Product
GIZ	Gesellschaft für Internationale Zusammenarbeit
GPDPD	Global Partnership on Drug Policies and Development
HIV	Human Immunodeficiency Virus
IDPC	International Drug Policy Consortium
INCB	International Narcotics Control Board
Lao PDR	Lao People's Democratic Republic
LGBTQ+	Lesbian, Gay, Bisexual, Transgender and Queer and others
NGO	Non-Governmental Organisation
NPS	New Psychoactive Substances
NSP	Needle and Syringe Programme
OAS	Organization of American States
OHCHR	Office of the High Commissioner for Human Rights
OST	Opioid Substitution Therapy
PEN Online	Pre-Expert Notification Online
SCOPE	Strategy for Coca and Opium Poppy Elimination
SDG	Sustainable Development Goal
UK	United Kingdom
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
UNDRIP	UN Declaration on the Rights of Indigenous Peoples
UNGASS	United Nations General Assembly Special Session
UNICEF	United Nations Children's Fund
UNODC	United Nations Office on Drugs and Crime
USA	United States of America
WHA	World Health Assembly
WHO	World Health Organization

Executive Summary

Objective of the Shadow Report

'Taking stock: A decade of drug policy' evaluates the impacts of drug policies implemented across the world over the past decade, using data from the United Nations (UN), complemented with peer-reviewed academic research and grey literature reports from civil society. The important role of civil society in the design, implementation, monitoring and evaluation of global drug policies is recognised in the 2009 Political Declaration and Plan of Action on drugs, as well as in the Outcome Document of the 2016 United Nations General Assembly Special Session (UNGASS) on drugs. It is in this spirit that the International Drug Policy Consortium (IDPC) has produced this Shadow Report, to contribute constructively to high-level discussions on the next decade in global drug policy.

Background

In 2009, the international community agreed on a 10-year global drug strategy with the adoption of the 'Political Declaration and Plan of Action on International Cooperation towards an Integrated and Balanced Strategy to Counter the World Drug Problem'. Article 36 of the Political Declaration established 2019 'as a target date for states to eliminate or reduce significantly and measurably' the illicit cultivation, production, trafficking and use of internationally controlled substances, the diversion of precursors, and money-laundering.

As this target date is fast approaching, member states have agreed to hold a two-day Ministerial Segment at the 62nd Session of the Commission on Narcotic Drugs (CND) to take stock of progress made and delineate the global drug strategy for the next decade. Both the mid-term review of the 2009 Political Declaration in 2014 and the 2016 UNGASS were missed opportunities for an honest and objective review of the successes and failures of global drug policies since 2009. Only a few months away from the 2019 high-level event, no comprehensive review of the impacts of drug policies worldwide has yet been undertaken. This Civil Society Shadow Report seeks to fill this gap, firstly by assessing the progress made, or lack thereof, against the objectives set in the 2009 Political Declaration and Plan of Action. Secondly, the Report considers whether global drug policy has contributed to, or undermined, the broader priorities of the UN of protecting human rights, advancing peace and security, and promoting development.

Key conclusions

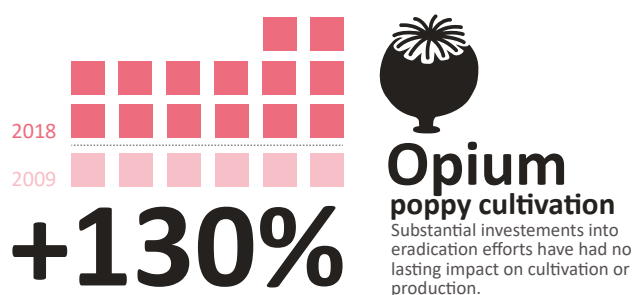
- Data from the Shadow Report show that the targets and commitments made in the 2009 Political Declaration and Plan of Action have not been achieved, and in many cases have resulted in counter-productive policies.
- The Shadow Report highlights the urgent need to conduct more comprehensive and balanced research and evaluations on the impacts of drug policies worldwide, taking into account government data, but also academic research and civil society findings.
- The Shadow Report concludes that member states should identify more meaningful drug policy goals and targets in line with the 2030 Agenda for Sustainable Development, the UNGASS Outcome Document and international human rights commitments.

Evaluating progress made against the targets included in Article 36 of the 2009 Political Declaration

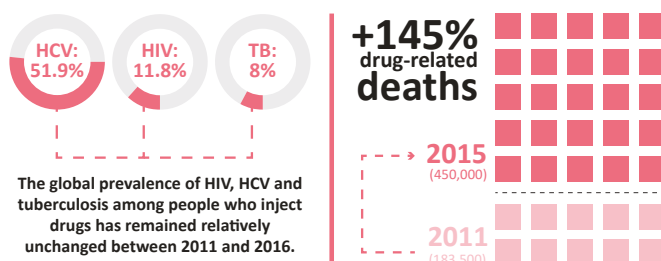
Target 1: Eliminate or reduce significantly and measurably 'the illicit cultivation of opium poppy, coca bush and cannabis plant'. Data from the United Nations Office on Drugs and Crime (UNODC) shows no reduction in the global scale of cultivation of opium, coca and cannabis between 2009 and 2018. Over this period, cultivation has in fact increased by 130% for opium poppy and by 34% for coca bush. As for cannabis, although recent global estimates are unavailable, the UNODC concluded that cultivation was reported in 145 countries in the period 2010-2016, with no sign of reduction.

Target 2: Eliminate or reduce significantly and measurably 'the illicit demand for narcotic drugs and psychotropic substances; and drug related health and social risks'. The overall number of people aged 15 to 64 who used drugs at least once in 2016 is estimated at 275 million, representing a 31% increase since 2011. The main drug of choice remains cannabis, followed by opioids, and amphetamines for which consumption has increased by 136% since 2011. The UNODC estimates that the global HIV prevalence among people who inject drugs has remained stable at 11.8%, as has the

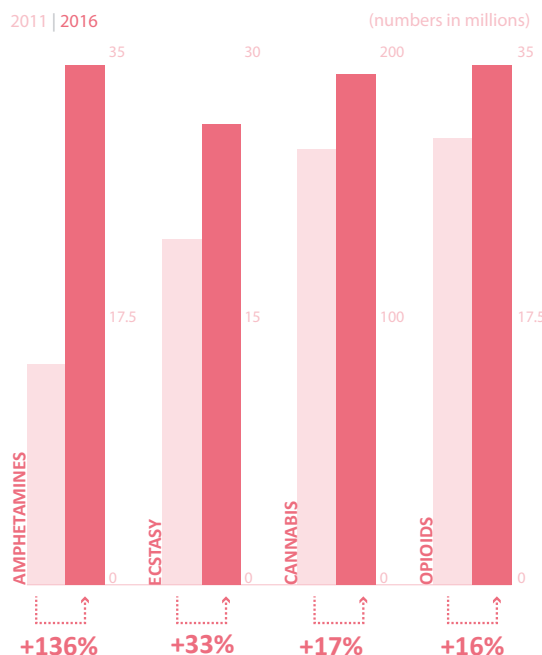
Illicit cultivation



Drug-related health risks



Illicit demand



global prevalence of hepatitis C at 51.9% and tuberculosis at 8%. Meanwhile, the number of drug-related deaths surged by 145%, from 183,500 deaths in 2011 to 450,000 in 2015.

Target 3: Eliminate or reduce significantly and measurably 'the illicit production, manufacture, marketing and distribution of, and trafficking in, psychotropic substances, including synthetic drugs'. Available UN data shows ongoing production and use of methamphetamines across the world with an expanding market in North and West Africa, North America, East and South East Asia and Oceania. In parallel, between 2009 and 2017, over 800 new psychoactive substances (NPS) have emerged on the global drug market, while the UN-ODC states that the illegal use of prescription drugs has reached record levels in various parts of the world, especially North America.

Target 4: Eliminate or reduce significantly and measurably 'the diversion of and illicit trafficking in precursors'. Despite efforts made by member states to control and monitor precursor chemicals, over the past five years the International Narcotics Control Board (INCB) has reported an increase in the use and number of precursors in illegal drug production. Furthermore, although seizures of precursor chemicals like potassium permanganate (used in the manufacture of cocaine) increased from 92,702 kg in 2012 to 585,072 kg in 2016, global cocaine production has risen by 44% since 2009.

Target 5: Eliminate or reduce significantly and measurably 'money-laundering related to illicit

drugs'. Although tighter national, regional and global policies and regulations have been adopted to counter money-laundering, the amount of money laundered globally each year amounts to US\$ 800 billion to 2 trillion, representing 2 to 5% of global GDP – with a quarter of overall revenues of transnational organised crime proceeding from drug sales. The global drug market is currently estimated to turnover between US\$ 426 and 652 billion. Of this, well over half of the gross profits generated are channelled into money-laundering, and less than 1% of the total amount of money being laundered is seized.

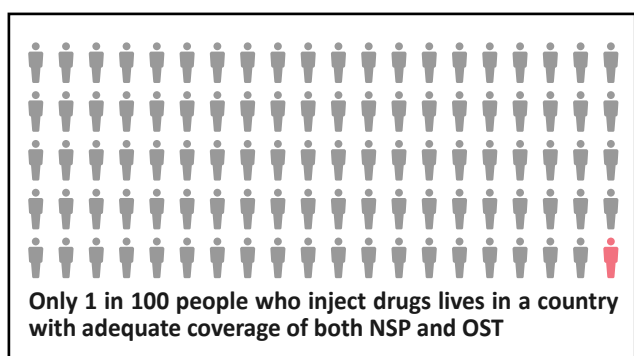
Assessing progress made towards the 2009 Plan of Action against the broader priorities of the United Nations

This section of the Shadow Report assesses progress made towards selected actions of the 2009 Political Declaration and Plan of Action. Progress is evaluated against the broader UN priorities of protecting human rights, promoting peace and security, and advancing development.

Protecting human rights

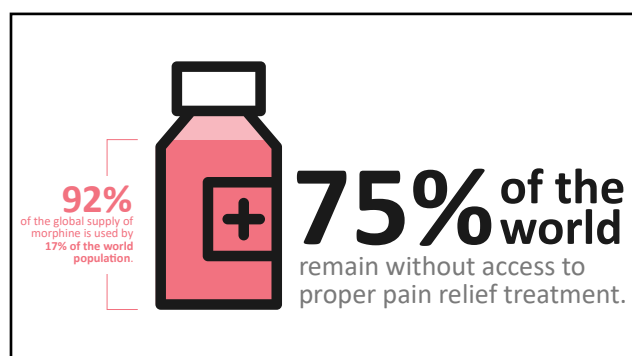
Over the past decade, overly punitive drug policies focusing on eradicating the illegal drug market have been associated with wide-ranging human rights violations and threats to public health and order. These abuses have had dire implications on the lives of marginalised people and communities worldwide.

The right to life: At least 3,940 people were executed for a drug offence over the past decade,



with 33 jurisdictions worldwide retaining the death penalty for drug crimes. Since 2009, various countries, including India, Iran, Malaysia, Palestine and Thailand, have taken steps to reduce or eliminate the use of capital punishment for drug offences, while others are considering reinstating the practice with bills in progress in Bangladesh, the Philippines and Sri Lanka. The recent escalation of punitive drug policies in South and South East Asia has resulted in the extrajudicial killings of over 27,000 people under Rodrigo Duterte's Presidency of the Philippines since June 2016.

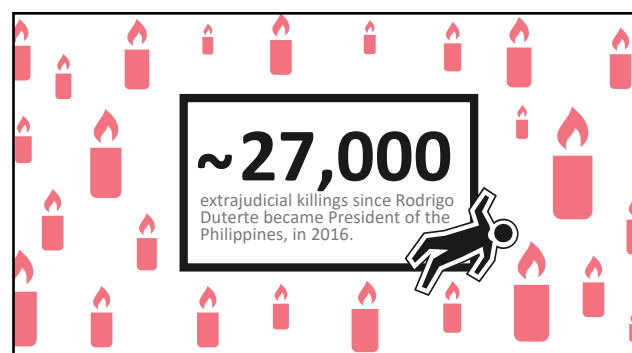
The right to health: Despite increases in the number of countries providing various harm reduction interventions, only 1% of people who inject drugs worldwide live in countries with adequate coverage of both needle and syringe programmes (NSPs) and opioid substitution therapy (OST). Access to harm reduction is even more limited in prisons and other places of detention, resulting in the prevalence of HIV, hepatitis B and tuberculosis among people in prison being two to ten times higher than among the general population. The surge in overdose deaths – in particular in the United States where over 71,000 people died of an overdose in 2017 alone – is also a major issue of concern. While the federal response in the United States has overwhelmingly been law enforcement focused, Canada – which has also been affected by a surge in overdose deaths – has adopted a number of public health measures, including the opening of 25 new drug consumption rooms since 2016. The criminalisation and stigmatisation



of people who use drugs has been identified by a number of UN agencies as a major barrier to accessing service provision. At national level, 26 countries have adopted a decriminalisation model to facilitate access to health services and reduce stigma and prison overcrowding.

Meanwhile, 75% of the world population, concentrated in the Global South, remain without access to essential medications for pain relief, while 92% of morphine is being used by just 17% of the world population. Overall reforms remain inadequate to address this issue. However, countries such as Costa Rica, India, Mexico, Uganda and Ukraine have recently taken various steps to improve access to morphine for palliative care and pain relief, and 48 countries have now established medicinal cannabis systems for a number of ailments.

Criminal justice rights and right to be free from torture: The Shadow Report also sheds light on the human rights associated with incarceration and disproportionate punishments. According to UN data, one in five prisoners worldwide is incarcerated for drug offences, the overwhelming majority of whom for drug possession for personal use. In certain regions, this proportion is even greater for women, as is the case in various Latin American countries, and in Thailand where over 80% of the 47,000 women in prison are incarcerated for a drug offence. In several countries, drug offenders also continue to be victims of excessive punishments, sometimes including acts of torture or other cruel, inhuman or degrading treatment. This includes forced urine



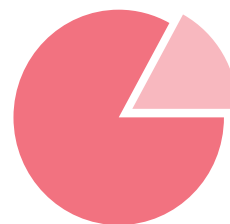
1 in 5

prisoners worldwide
are incarcerated for
drug offences



In some parts of the world, **over 80% of women** incarcerated are serving sentences for drug-related offences.

~83%
serve sentences for
drug possession for
personal use



testing, compulsory registration requirements, incarceration in compulsory detention centres and corporal punishment, including on children. At the same time, tens of thousands of people have recently been arbitrarily arrested in Cambodia and Bangladesh for suspected involvement in illicit drug activities. Although discussions have been held at regional and international levels on these issues, on the ground little progress has been made to remedy these human rights abuses.

Promoting peace and security

Instead of reducing the overall scale of the illegal drug market, overly punitive drug policies have often exacerbated violence, instability and corruption. In the case of opium, while cultivation fell in South and South East Asia over the past decade, it has increased significantly in Afghanistan which now produces 86% of the world's opium. Academic research concluded that forced eradication campaigns had led to increased levels of crime, an ongoing Taliban insurgency and militias remaining active in the region, with severe consequences for subsistence farmers. Similarly, despite forced crop eradication campaigns in Colombia, coca cultivation increased by 115% between 2009 and 2016. Interdiction efforts in the country have resulted in violent clashes between affected communities and the police and the military, forcing millions of people to be internally displaced. In Mexico, a militarised war on drug cartels launched in 2006 resulted in over 150,000 deaths associated with the drug trade and more than 32,000 disappearances. In West Africa, several

countries are now considered as drug trafficking hubs, with the collusion between high-level officials and traffickers constituting a major threat to security, governance and development.

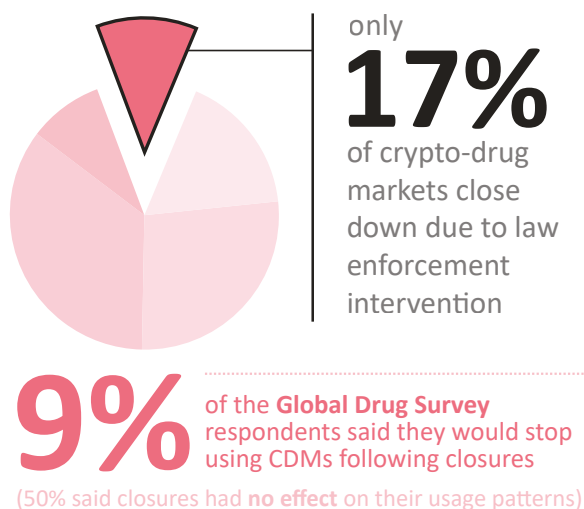
Posing an additional layer of complexity, the development of crypto-drug markets has forced policy makers to adapt their law enforcement strategies. However, available data show that only 17% of crypto-drug markets were closed down as a result of drug law enforcement interventions; the rest having been shut down because of exit scams, voluntary closure or hacking. Further studies concluded that only a small minority of those purchasing drugs in crypto-drug markets stopped using these markets because of drug law enforcement action – putting into question the efficacy of current drug control efforts. Nevertheless, the rise in the use of online drug markets has led to interesting developments in the field of health and harm reduction. For instance, online forums within crypto-drug markets have facilitated peer-based reviews and feedback on drug purchases, sellers, purity and effects of products bought online, enabling people who use drugs to reduce health harms, and facilitating discussions on the availability of drug support services.

Advancing development

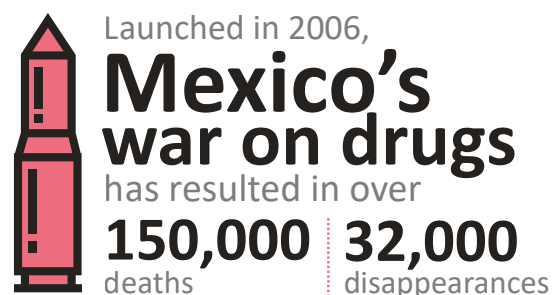
Tracking progress towards development – and the Sustainable Development Goals (SDGs) – constitutes the third key analytical research area of this Shadow Report. Evidence collected for the Report shows that drug control efforts have mainly

Assessing progress on Peace and security

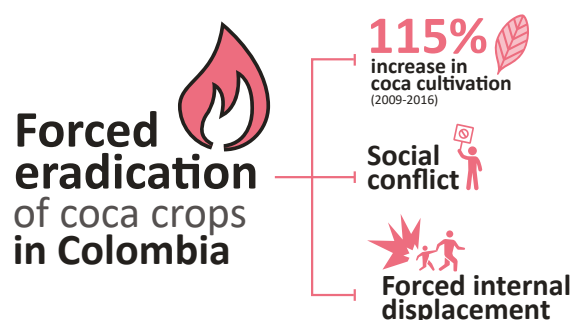
Crypto-drug markets



War on drugs and violence



Eradication and social conflict



consisted of eradication measures, with little attention given to the critical development issues faced by affected communities in rural and urban contexts.

Although alternative development has gained much visibility in UN forums and discussions over the past decade, such programmes have generally been used to justify crop eradication campaigns, rather than focusing on creating the conditions that improve people's livelihoods and reduce their dependence on illegal crop cultivation. The use of harmful pesticides to destroy drug crops has impacted upon the health of local communities and damaged the environment by displacing subsistence farmers into new, more remote areas, including national parks and indigenous territories. In Colombia, 32% of coca is cultivated in national parks and indigenous reserves. In recognition of concerns over human and environmental harms associated with harmful pesticides, Bolivia, Ecuador, Peru and Thailand have banned the use of these chemical agents.

While alternative development programmes have mostly been counter-productive, two country examples stand out as more positive models. Since the 1960s, Thailand has adopted a long-term development strategy in areas where illegal opium cultivation was concentrated. This approach has led

to reductions in poverty levels through increased access to education, employment, basic health and social services and infrastructure. On the other side of the world, since 2008 Bolivia has allowed farmers to grow a sufficient amount of coca for subsistence purposes, facilitating access to a national legal market for coca products, as well as improving access to safe water, education and other sources of income. Both the Thai and Bolivian models rely on strong community participation.

As in areas of illicit crop cultivation, poverty has now been recognised as a main driver of engagement in illicit drug trafficking and other supply-side activities. In Latin America, the overwhelming majority of women incarcerated for drug offences are first time, non-violent offenders, with limited formal education or employment opportunities and the sole care provider of several children and other dependents, who engage in illegal drug activities because of situations of socio-economic vulnerability. Although these issues are better understood and visible in regional and global forums, few member states have taken action on the ground. Costa Rica is a notable exception. Since 2013, the country has adopted a number of reforms to reduce the high rate of incarceration of women in situation of vulnerability, by ensuring more proportionate sentences for certain

Bolivia's community coca control



Regulated legal cultivation

Registered growers can grow on a limited extension of land.



Enforced regularly

By both local growers unions and state agencies.



Investment in development

Non-conditional support in coca-growing areas.



Constitutional protection

The Constitution asserts the plant's cultural significance.

drug offences, providing alternatives to incarcerations and offering social and health support for those in need.

What next: Designing new benchmarks for global drug policy

The 2016 UNGASS was instrumental in expanding the scope of global drug policy debates beyond the siloed three pillars of demand reduction, supply reduction and international cooperation to also focus on health (including harm reduction and access to controlled medicines), development, human rights and new challenges. Going forward, this seven-pillar structure should prevail in global drug control debates.

This Shadow Report demonstrates that the objective of achieving a drug-free world is unrealistic and unachievable. The pursuit of 'drug-free world' targets has resulted in policies and punitive enforcement practices which have undermined health, human rights, development and security. Beyond 2019, the overall goals of global drug policy – as well as the metrics and indicators used to evaluate progress – urgently need to be reconsidered. New goals, metrics and indicators should be aligned both with the UNGASS Outcome Document and the SDGs, and focus on the critical need to minimise drug-related health harms, improve access to healthcare, uphold basic human rights, ensure gender equality, reduce poverty in cultivation and trafficking areas, improve citizen safety and reduce corruption. A detailed list of indicators is proposed in the final section of the Shadow Report.

Conclusion

The commitments and targets set in the 2009 Political Declaration and Plan of Action have not been achieved, and in many cases have resulted in counter-productive policies. The Shadow Report also raises a number of issues on the past and future evaluation of global drug policies. Firstly, the Report highlights the urgent need to conduct more thorough and regular research on the broader range of impacts of drug policies at local, national, regional and international level.

Secondly, and related to the need for more research, the Report puts into question the sources of data currently being used for such formal evaluations. These rely heavily on government reporting. A more comprehensive and balanced picture of the situation requires incorporating civil society and academic research. This is particularly important for sensitive issues related to drug policy and human rights.

And thirdly, the lack of progress made towards the drug-free targets, along with the negative consequences associated with efforts to achieve those targets, mean that member states should reflect upon *what* to measure. Focusing exclusively on measuring the scale of the illegal drug market is clearly not enough to understand the impact of drug policy on the key UN Charter commitments to health, human rights, development, peace and security. The third section of this Shadow Report attempts to provide some recommendations which we hope will provide a useful starting point for further discussions as to which goals and metrics could be considered for the post-2019 global drug strategy.

Recommendations

In preparation for the 2019 Ministerial Segment, the IDPC network recommends that:

- The international community should consider adopting more meaningful goals and targets in line with the 2030 Agenda for Sustainable Development, the UNGASS Outcome Document and international human rights commitments, and move away from targets seeking to eliminate the illegal drug market.
- Post-2019, member states should meaningfully reflect upon the impacts of drug control on the UN goals of promoting health, human rights, development, peace and security – and adopt drug policies and strategies that actively contribute to advancing the 2030 Agenda for Sustainable Development, especially for those most marginalised and vulnerable.
- Global drug policy debates going forward should reflect the realities of drug policies on the ground, both positive and negative, and discuss constructively the resulting tensions with the UN drug control treaties and any human rights concerns associated with drug control efforts.
- Beyond 2019, UN member states should end punitive drug control approaches and put people and communities first. This includes promoting and facilitating the participation of civil society and affected communities in all aspects of the design, implementation, evaluation and monitoring of drug policies.



Part 1

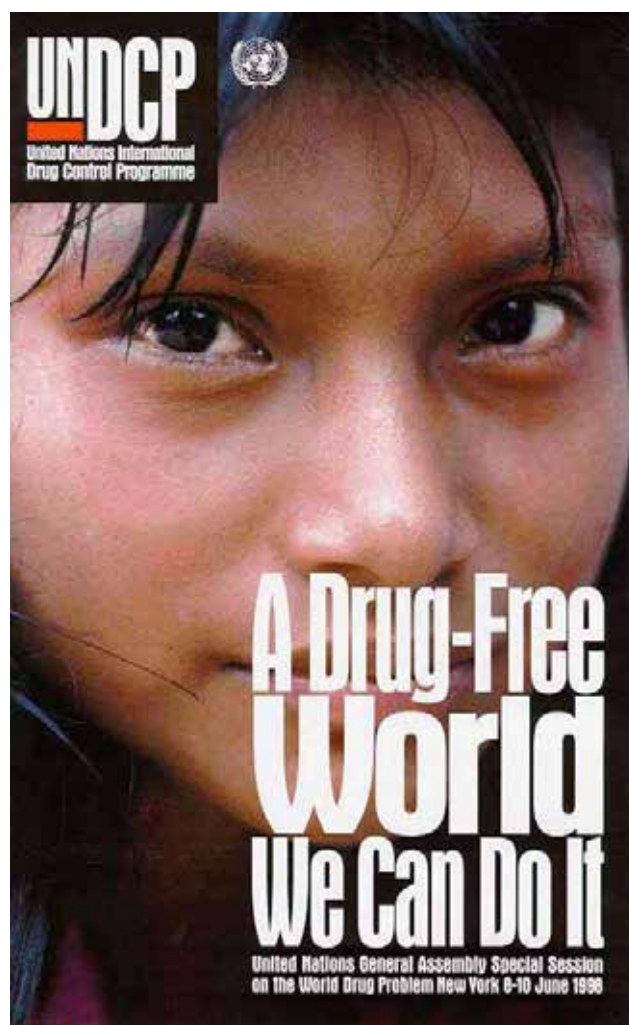
Introduction

1 Background

In March 2009, the 52nd session of the Commission on Narcotic Drugs (CND) featured a High-Level Segment held in Vienna,¹ with a view to define the international community's 10-year global drug strategy. The event resulted in the adoption, by consensus, of the '2009 Political Declaration and Plan of Action on International Cooperation towards an Integrated and Balanced Strategy to Counter the World Drug Problem'.² In order to understand the implications of the 2009 process and the ensuing framework for international drug policy,³ it is critical to analyse the period running up to 2009.

1.1 The UNGASS decade: 'A drug-free world, we can do it'

The first ever UN General Assembly Special Session (UNGASS) on drugs was held in 1990, at which member states adopted a Political Declaration to strengthen the global approach.⁴ Eight years later, UN member states assembled again in New York at a second UNGASS on the 'world drug problem' under the strapline 'A drug-free world, we can do it'.⁵ Echoing this overarching objective, the UN International Drug Control Programme had originally proposed the adoption, at the 1998 UNGASS, of the SCOPE plan – i.e. the 'Strategy for Coca and Opium Poppy Elimination' by 2008. Supported by the USA, the plan was met with strong criticism from NGO groups, and preventing its adoption became one of their main priorities. The fact that this plan was not adopted as the main outcome of the 1998 UNGASS was an important success for civil society.⁶ What remained of the SCOPE Plan was the inclusion, in the 1998 Political Declaration (S-20/2),⁷ of paragraph 19: 'Welcome the global approach by the United Nations International Drug Control Programme to the elimination of illicit crops, and commit ourselves to working closely with the Programme to develop strategies *with a view to eliminating or reducing significantly the illicit cultivation of the coca bush, the cannabis plant and the opium poppy by the year 2008*' (emphasis added).⁸ In a way, the SCOPE plan gave birth to the

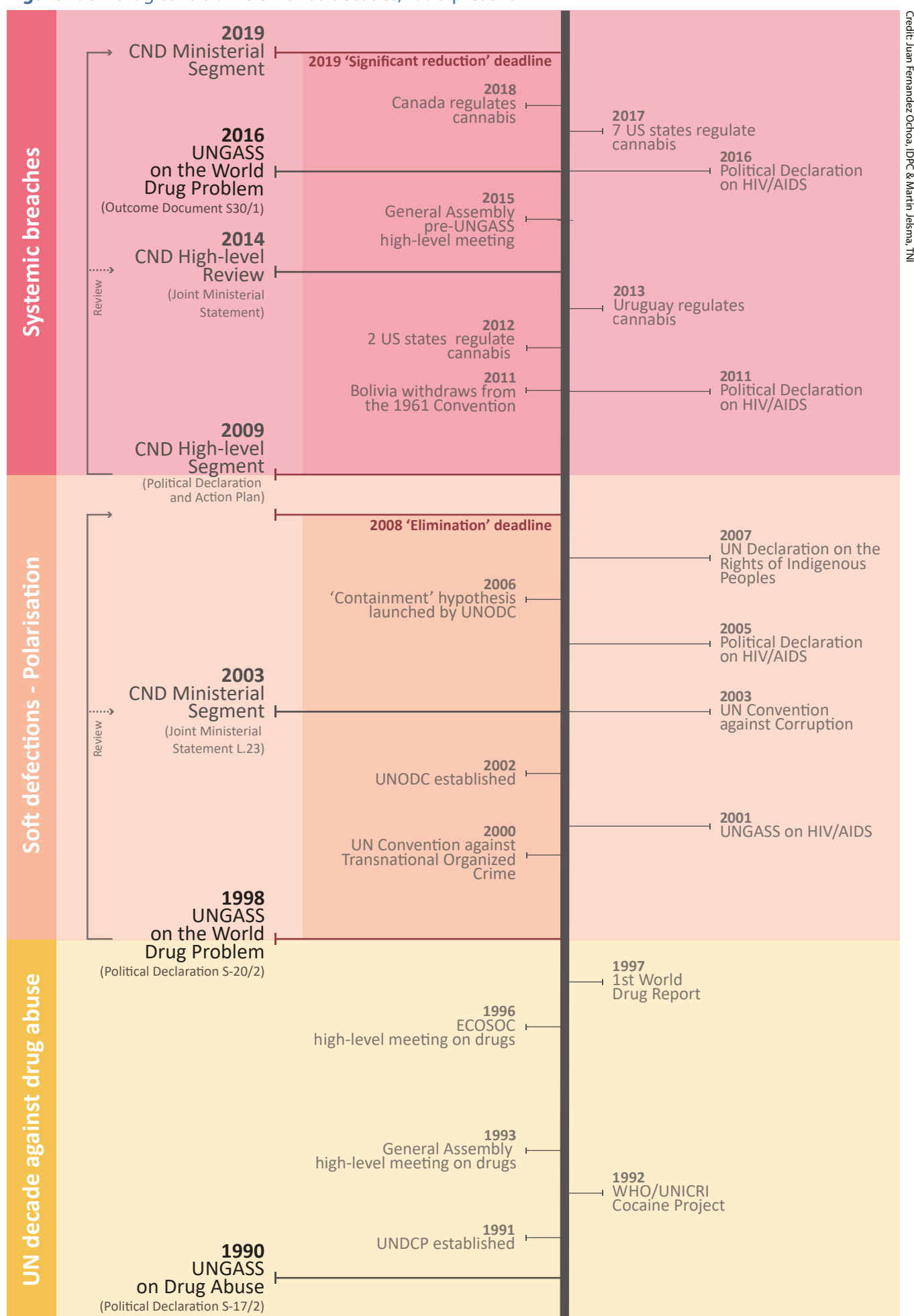


Credit: United Nations International Drug Control Programme

targets to eliminate the global illegal drug market with a first target period running until 2008, and which was then reiterated for the following decade. 1998 also marked an important shift in focus from a historical emphasis on supply reduction to focus both on demand and supply, with the adoption of the 'Declaration on the guiding principles of drug demand reduction'.⁹

Ten years later, as the end of this 'UNGASS decade' was approaching, available data at the time showed no reduction in the overall scale of the illegal drug market. In its 2008 World Drug Report, and in particular its thematic chapter entitled 'A century of international drug control', the United Nations Office

Figure 1. UN drug control: The UNGASS decades, 1990-present



Credit: Juan Fernandez Ochoa, IDPC & Martin Jelsma, TNI

on Drugs and Crime (UNODC) developed a 'containment' rhetoric,¹⁰ explaining that statistical evidence showed that drug use prevalence had remained stable since the adoption of the 1909 Shanghai Commission. Drug use prevalence, the UNODC stated, had 'been contained to less than 5% of the adult population'.¹¹ The containment argument, however, was criticised for its reliance on 1909 data a benchmark for comparison – opium, for instance, was relied upon for the medicinal treatment of multiple illnesses in 1909, and its use then cannot be compared with non-medical opium or heroin use in the 21st century.¹²

In March 2008, Antonio Maria Costa also produced a seminal paper presented at the 51st session of the CND in the form of a conference room paper: 'Making drug control "fit for purpose": Building on the UNGASS decade'.¹³ Recognising that 'Some of the more ambitious targets set at UNGASS in 1998 remain elusive', the UNODC Executive Director openly acknowledged the 'unintended consequences' associated with the dominant approach to drug control:

- 'A huge criminal black market that now thrives'
- 'Policy displacement', with an imbalance of public resource allocation towards drug law enforcement at the expense of public health and social interventions
- 'Geographical displacement', also called 'the balloon effect', meaning that the rare successes in reducing cultivation or trafficking in one area merely lead to increases elsewhere
- 'Substance displacement', with tighter controls on certain drugs leading suppliers and people who use drugs to turn to other substances, sometimes with unintended consequences for health
- 'The way we perceive and deal with the users of illicit drugs', in other words, the stigmatisation of drug use, which has resulted in the marginalisation and discrimination of people who use drugs and has negatively impacted their access to healthcare and social services.¹⁴

Meanwhile, in recognition of the severe consequences of punitive drug policies, reforms were materialising at national level, with an increasing number of governments supporting harm reduction measures and moving towards the decriminalisation of drug use and possession for personal use. It is in this context that member states initiated the negotiations process for the post-2008 global drug control strategy.

1.2 The 10-year review of the 1998 Political Declaration

The High-Level Segment of the 52nd session of the CND in 2009 concluded a year-long review of the 1998 UNGASS targets. To 'allow additional time for conducting an objective, scientific, balanced and transparent global assessment',¹⁵ member states had decided to divide the review process into three stages:

- A thematic debate at the 51st session of the CND in 2008 to discuss the outcomes of the assessment conducted by the UNODC on global progress against the 1998 Political Declaration.¹⁶ 'Making drug control "fit for purpose"' was an integral part of this review.
- A 'period of reflection' during which five inter-governmental expert working groups¹⁷ elaborated a number of recommendations on demand reduction, supply reduction, money-laundering and judicial cooperation, eradication of illegal drug crops and alternative development, and precursors and amphetamine-type stimulants (ATS).¹⁸ The conclusions of the expert working groups provided the materials upon which the new strategy post-2008 would be drafted.
- The negotiation of a new Political Declaration and Plan of Action, which was adopted by consensus at the High-Level Meeting of March 2009.

Civil society used this review period to organise a series of consultations and meetings. This culminated in the Global Civil Society Forum, held in July 2008 and attended by over 300 civil society representatives who worked together to agree on the 'Beyond 2008 Declaration'.¹⁹ The Declaration was formally presented at the 52nd session of the CND.²⁰

1.3 The 2009 Political Declaration and Plan of Action: Setting a new target date

The 2009 'Political Declaration and Plan of Action on International Cooperation towards an Integrated and Balanced Strategy to Counter the World Drug Problem' recognises that 'the commitments made by Member States in 1998 to attain significant and measurable results in the area of drug demand reduction have been attained only to a limited extent' and that 'despite some significant progress made in certain areas, efforts have not led to a significant overall decrease in the global illicit cultivation of crops used for the production

of narcotic drugs and psychotropic substances.²¹ However, in many respects, the 2009 Political Declaration is very similar to the declaration that emerged from the 1998 UNGASS and the objectives established in 2009 are comparable to those formulated ten years before:

‘the ultimate goal of both demand and supply reduction strategies and sustainable development strategies is to minimize and eventually eliminate the availability and use of illicit drugs and psychotropic substances... We are determined to tackle the world drug problem and to actively promote a society free of drug abuse in order to ensure that all people can live in health, dignity and peace, with security and prosperity’.²²

The objectives flowing from this goal led member states once again to: ‘establish 2019 as a target date for States to eliminate or reduce significantly and measurably:

- a. The illicit cultivation of opium poppy, coca bush and cannabis plant;
- b. The illicit demand for narcotic drugs and psychotropic substances; and drug related health and social risks;
- c. The illicit production, manufacture, marketing and distribution of, and trafficking in, psychotropic substances, including synthetic drugs;
- d. The diversion of and illicit trafficking in precursors;
- e. Money-laundering related to illicit drugs’.²³

The High-Level Segment itself reflected several points of contention between member states on the direction of global drug control, in particular on the concept of harm reduction. A few member states fought a long and protracted battle to include the term in the document, but it was eventually removed, even as a footnote, during the negotiations and ultimately replaced with the term ‘related support services’. However, reflecting the increasing level of support for a health-based approach towards drug use, a group of 26 member states²⁴ led by Germany made a joint statement at the 2009 Segment declaring that they would interpret the term ‘related support services’ to mean ‘harm reduction measures’.²⁵ This was one of the early signs that cracks in the ‘Vienna consensus’²⁶ were forming. Nonetheless, in the years that followed, the Political Declaration – with its ‘drug-free world’ goals at the centre – became a key document of reference for the international community in its efforts to control the illegal drug market.

1.4 The 2014 mid-term review of the 2009 Political Declaration: A missed opportunity

The first occasion to review progress made against the goals established in 2009 was five years later in 2014, with the mid-term High-Level Review of the Political Declaration, held at the 57th session of the CND. The event, however, mainly consisted of country statements at a 2-day summit in Vienna and difficult negotiations over a consensus-based document, rather than an objective assessment of what had been achieved so far.²⁷ While the discussions acknowledged the continued challenges related to drug control, the resulting Joint Ministerial Statement mostly reiterated the themes of the 2009 Political Declaration and Plan of Action. The Joint Ministerial Statement²⁸ also made no reference to the lack of progress made towards the achievement of the target of halving new HIV infections among people who use drugs by 2015, which had been agreed by the UN General Assembly through a majority vote in the 2011 Political Declaration on HIV/AIDS.²⁹

In 2014, some unprecedented reforms had taken place at national level, and perhaps in reflection of these changes, reaching consensus at the UN became increasingly difficult. At the time, Bolivia had withdrawn from the 1961 Single Convention on Narcotic Drugs (the first and only country to do so) and re-acceded with a reservation on coca leaf chewing.³⁰ Various US states³¹ and Uruguay³² had adopted regulatory regimes for non-medical cannabis use, and around 20 countries had established a form of decriminalisation, whether *de jure* or *de facto*, of drug possession for personal use.³³ In addition, calls for more humane, health-centred drug policies – including a harm reduction approach and the abolition of the death penalty for drug offences – were increasingly vocal.

These developments had a significant impact on the dynamics at the CND in Vienna. For the first time in the history of the international drug control regime, a member state (Ecuador) called in its official statement for a reform of one of the three UN drug conventions³⁴ – breaking a taboo that had long remained sacrosanct at the CND. These views were met by a more conservative front led by the Russian Federation.³⁵ It is unsurprising, therefore, that it took over nine months for the Joint Ministerial Statement to be negotiated during intense debates, resulting in a relatively bland, watered-down document. The difficult negotiations contributed to a growing sense of frustration among many member states.³⁶



Opening session of the 2016 UNGASS on drugs

1.5 The 2016 UNGASS: The winds of change

Even before the 2014 high-level review, a sense of exasperation was growing amongst those states seeking reform, particularly in Latin America, a region which was experiencing increasing levels of violence as a result of overly punitive drug policies. At the 2012 Summit of the Americas, most of the presidents of the region met privately to discuss drug policy and called on the Organization of American States (OAS) to analyse the results of present policies and explore alternatives. Shortly thereafter, the governments of Colombia, Guatemala and Mexico were successful in getting the issue of drug policy reform on the UN agenda. At the 2012 UN General Assembly meeting, those countries issued a formal statement underscoring the need to ‘review the approach’ of present drug policies and called on the UN to ‘exercise its leadership...and conduct a profound reflection to analyze all available options, including regulatory or market measures, in order to establish a new paradigm that prevents the flow of resources to groups involved in organized crime’. The statement concludes by asking the UN to host ‘an international conference to allow the necessary decisions to be made in order to achieve more effective strategies and tools with which the global community faces the challenges of drugs and their consequences.’³⁷ The convening of a third UNGASS on drugs was agreed within the Omnibus Resolution adopted by the UN General Assembly in December 2012.³⁸

Held in New York on 19 to 21 April 2016, the third UNGASS on drugs was characterised by surface consensus and underlying conflict. As was the case in 2014, negotiating the UNGASS Outcome Document³⁹ was highly challenging, the divide being greater than ever on the key substantive issues of global drug control.⁴⁰ Once again, human rights, the death penalty in particular, and harm reduction were at the forefront of the tensions between member states.⁴¹ While strong statements on these issues were made throughout the proceedings, neither was explicitly included as such within the final declaration, although key harm reduction interventions were referenced for the first time in such a high-level document on drug control.⁴² These underlying tensions reflected a deeper division between the narrative of achieving a ‘drug-free society’ and the view that this goal is unattainable and that drug policies should be trying to manage the ‘drug problem’ in a way that minimises potential harms as much as possible for individuals and affected communities. The resultant 26 page-long Outcome Document was a significant improvement over previous high-level declarations on drug policy, with unprecedented visibility given to certain human rights concerns (e.g. abuses in the context of law enforcement, proportionality of sentencing and gender equality), public health (including access to controlled medicines) and development, which was also reflected in a new 7-pillar thematic structure for member state discussions, breaking with the three traditional pillars of demand reduction, supply reduction and international cooperation.⁴³

Box 1 The INCB's shifting position on selected drug policy issues: A 10-year review

Historically, the International Narcotics Control Board (INCB) has been considered as the most conservative UN drug control body, with vocal statements against states having adopted harm reduction and decriminalisation policies, and little condemnation of drug policies raising human rights concerns. However, over the past decade the Board's positions have evolved on a number of drug policy issues.

A key development has been the move from the INCB's refusal to take a stance on the death penalty for drug offences to regular calls for UN member states to abandon the practice.⁴⁴ More recently, the INCB condemned the extrajudicial killings of suspected drug offenders – albeit after intense pressure from civil society⁴⁵ – as 'a serious breach of the legal obligations to which the Philippines is held by the three UN drug control conventions and by the corpus of international legal instruments to which the country has adhered'.⁴⁶ Meanwhile, the Board has remained consistent in its calls for more proportionate sentencing, which was first touched on in 1996, and expanded in the thematic chapter of the INCB's 2007 Annual Report.⁴⁷ The INCB has advocated for proportionate sentencing repeatedly since then.⁴⁸

Another major change relates to the INCB's position on decriminalisation. In 2015, the Board concluded that: 'The treaties do not require the incarceration of drug users, but rather provide for alternatives to conviction or punishment for those affected by drug abuse...That some countries have chosen incarceration rather than treatment has been a denial by governments of the flexibility that the treaties provide'.⁴⁹ Going a step further in supporting decriminalisation, the INCB spoke at a side event at the 58th session of the CND on the Portuguese decriminalisation model.⁵⁰

Similarly, there has been a noticeable difference of tone on medicinal cannabis. In 2013, the INCB President had pronounced: 'If such "medical" schemes are not well managed and supervised, they could be seen as "backdoor legalisation" of cannabis for recreational use'.⁵¹ More recent publications by the Board have acknowledged the legality of medicinal cannabis use under the 1961 convention, and focused on discussing the technical, administrative and legal factors involved.⁵²

With regards to harm reduction, the INCB has remained timid on drug consumption rooms. The Board was highly critical of this intervention in past Annual Reports, stating in 2005 that 'Drug injection rooms contravene the major principle of the treaties'.⁵³ The 2016 Report was considered as softening the Board's stance, at least in terms of the tone of its remarks, limiting its comments to technical and legal questions, implying that when certain conditions are fulfilled, such facilities do operate in line with the drug control treaties.⁵⁴ In its 2017 Report, however, the Board again expressed reservations concerning the fact that users of the facilities acquired their drugs prior to entering the drug consumption rooms, and utilising stigmatising language such as 'drug abusers' – representing subtle indications of a retraction of the 2016 position.⁵⁵

Identifying ways of addressing the existing tensions between the rights of indigenous groups and member states' obligations under the UN drug control treaties (see [Box 13](#)) is another matter on which the INCB has not yet adopted a clear position – although the INCB President recognised that 'there are in fact contradictions' but that 'in the current state of drug control legislation' allowing indigenous groups to use internationally controlled substances for traditional purposes 'is not possible'.⁵⁶

Yet another issue of concern remains the culture of lack of transparency in the INCB's work. The Board meets in secret, and no minutes of its meetings are published. Further, there is no public access to the analysis through which it arrives at its policy positions,⁵⁷ and reports from country visits are not made available online or shared with member states. However, adding some transparency to the Board's functioning, the INCB's engagement with civil society has also improved since 2009. The Board now undertakes a yearly dialogue with civil society at the CND, and regularly meets with NGOs during its most country visits. Further, the Board held a meeting with civil society delegates in May 2018 – the first of its kind – in order to discuss the medical and non-medical uses of cannabis.⁵⁸

The INCB has come a long way since 2009, but there remains some way to go before the Board can become the champion of human rights and public health it appears as in its rhetoric.

The fact that the Sustainable Development Goals (SDGs)⁵⁹ were agreed just a few months before the UNGASS Outcome Document⁶⁰ contributed to the incorporation of a more visible development perspective within the UNGASS proceedings and the Outcome Document, with a whole chapter dedicated to the issue independently from supply reduction imperatives, and a broader perspective focusing both on rural and urban settings.

Nevertheless, a genuine evaluation of global drug policies once again failed to materialise. The UN Secretary General had encouraged member states to use the UNGASS in order to 'conduct a wide-ranging and open debate that considers all options'.⁶¹ However, the discussions remained entrenched in the usual narrow diplomatic parameters, with no reconsideration of the harms caused by drug control policies, and with the goal of promoting 'a society free of drug abuse' reaffirmed and featuring prominently in the preamble of the Outcome Document.⁶² As in 2014, the establishment of regulated markets in some member states for non-medical use remained the 'elephant in the room', with almost no discussions held on the inherent resulting tensions for the global drug control regime. As a result, despite some undeniable progress, there was no fundamental shift in the underlying punitive enforcement-led drug control paradigm, except for one singularly pivotal element: for the first time in two decades, and apart from an inclusion in the preamble of the need to achieve a 'society free of drug abuse', no explicit mention was made of the detailed 'drug-free world' targets as they had been laid out in paragraph 19 of the 1998 Political Declaration and paragraph 36 of the 2009 Political Declaration.

1.6 The next step: The 2019 Ministerial Segment of the 62nd CND

The next step on the international drug policy roadmap will be in March 2019 – with a high-level Ministerial Segment scheduled before the 62nd session of the CND. A core objective of this event is to 'take stock of' progress made during the decade since the adoption of the 2009 Political Declaration and Plan of Action, with a view to delineating the global drug strategy for the next decade.⁶³ The event is particularly timely considering the significant changes that have taken place since 2009. The illegal drug market has become more complex, with changing production regions and trafficking routes, the increasing use of online markets, and new drugs and drug use behaviours. The division between production, trafficking and consumption countries has also become increasingly blurred. In the meantime, local and national drug policies have changed dramatically over the past decade, with some countries moving towards a harm reduction approach, decriminalisation and even regulated markets for certain substances, while others have escalated their punitive approach to counter supply and demand. In this rapidly changing environment, a review of progress made since 2009 and an evaluation of whether the 2009 strategy remains 'fit for purpose' constitute key priorities. Only a few months away from the Ministerial Segment, however, no such review has been undertaken.

2 Objective of this shadow report

Both the 2014 High Level Review and the 2016 UNGASS were missed opportunities for an honest and objective review of the successes and failures of global drug policies since the adoption of the 2009 Political Declaration and Plan of Action. As the target period as set forth in paragraph 36 of the 2009 Political Declaration is set to expire in 2019, and with the Ministerial Segment of the 62nd session of the CND drawing near, no independent evaluation has yet taken place. Biennial reports on the implementation of the Political Declaration were published by the UNODC Executive Director in 2012, 2014, 2016 and 2018,⁶⁴ but like the UNODC World Drug Reports, these rely on member states' responses to the Annual Report Questionnaire (ARQ), and therefore represent an incomplete and subjective picture of the overall drug control landscape. Furthermore, these reports focus almost exclusively on the scale of the illegal drug market, with little attention given to issues related

to human rights, public health and development – although it should be noted that the more recent World Drug Reports have made efforts to provide more analysis of these aspects.

In an attempt to help fill this gap, the objective of this 'Shadow Report' is three-fold. Firstly, it assesses the progress made, or lack thereof, against the objectives set out in the 2009 Political Declaration and Plan of Action. Secondly, we evaluate whether and how the implementation of the Political Declaration and Plan of Action may have contributed to, or undermined, the broader priorities of the United Nations, namely protecting human rights, advancing peace and security and promoting development. Thirdly, we offer recommendations for the 2019 Ministerial Segment and the next decade in drug policy, focusing on the implementation of the UNGASS Outcome Document and the achievement of the SDGs.

3 Methodology

The 2009 Political Declaration and its Plan of Action recognise the ‘important role played by civil society’ in the ‘formulation and implementation’ of drug policy (Action 10). Action 12(b) also requests member states to ‘involve all stakeholders at the community level (including the target populations, their families, community members, employers and local organizations) in... monitoring and evaluation of demand reduction measures’. In light of these Actions, the International Drug Policy Consortium (IDPC) has worked with its network of civil society members and partners to evaluate progress against the 2009 goals and targets, with the aim of contributing to the debates in the lead up to, and during, the 2019 Ministerial Segment.

This report does not seek to provide a comprehensive repository of all available data on drugs, but rather an analysis of the most relevant information available regarding what is known about key achievements and failures of the global drug control regime between March 2009 and July 2018. 45 experts from within civil society, academia, governments and UN agencies peer reviewed the report to ensure its validity and robustness (see [Acknowledgements](#) section above).

In preparation for this report, IDPC identified key actions within the 2009 Political Declaration and Plan of Action against which to measure progress. Two criteria were used to select which ones to focus on in this Shadow Report. Firstly, for each action, an assessment was made as to whether the target was tangible and quantifiable, and how progress could be measured towards its achievement against the UN priorities of protecting human rights, promoting

peace and security and advancing development. Secondly, actions were selected according to the key priorities of the IDPC network – in particular those related to improving health, human rights, human security, social inclusion and development, in line with IDPC’s vision⁶⁵ and policy principles.⁶⁶ Following this process, 33 actions were selected for this report and are listed, along with the relevant issue they relate to, in the [Annex](#).

For each selected action, desk-based research was conducted to measure progress and remaining challenges. The research aimed to identify comparable data when available (taking into account methodological divergences in research conducted between 2009 and 2018), but also to provide qualitative information on whether or not the objectives set out in 2009 were achieved. IDPC reviewed the UNODC Biennial Report for 2018, the UNODC World Drug Reports published between 2009 and 2018, documentation from UN agencies and civil society, and academic research – all of which are cited throughout this document. The results of this research form the basis of the conclusions presented in [Part 2](#). The findings of the Shadow Report are further supplemented by case studies aiming to show the human impacts – both positive and negative – of the past decade of international drug control.

[Part 3](#) of the Shadow Report looks to the future, analysing the gains achieved within the UNGASS Outcome Document, and offering recommendations on how to leverage the SDGs to develop new metrics and indicators against which to measure the progress in global drug policy for the next decade.

Part 2:

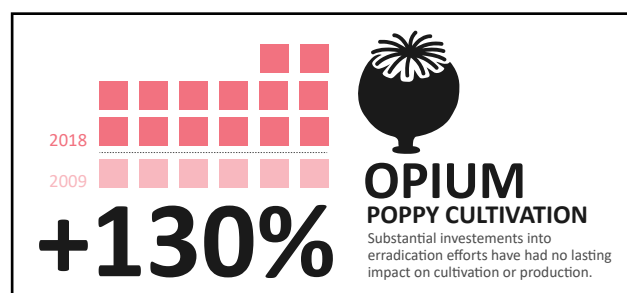
Evaluating progress made in addressing the ‘world drug problem’ since the adoption of the 2009 Political Declaration and Plan of Action

1 Assessing progress made against Article 36 of the 2009 Political Declaration

Article 36 of the 2009 Political Declaration is perhaps one of the most significant, as it established 2019 as the target date 'to eliminate or reduce significantly and measurably

- the illicit cultivation of opium poppy, coca bush and cannabis plant;
- the illicit demand for narcotic drugs and psychotropic substances; and drug related health and social risks;
- the illicit production, manufacture, marketing and distribution of, and trafficking in, psychotropic substances, including synthetic drugs;
- the diversion of and illicit trafficking in precursors; and
- money-laundering related to illicit drugs.⁶⁷

This section discusses progress made against each of these objectives, drawing from official data provided by the UNODC (see [Box 2](#)), in particular the World Drug Reports from 2009 to 2018 and the latest biennial report of the UNODC Executive Director on 'Action taken by Member States to implement the Political Declaration and Plan of Action on International Cooperation towards an Integrated and Balanced Strategy to Counter the World Drug Problem', published in March 2018⁶⁸ – taking due account of issues related to quality and gaps in the UNODC's data (see [Box 2](#)).



Credit: Juan Fernandez Ochoa, IDPC

1.1 The illicit cultivation of opium poppy, coca bush and cannabis plant

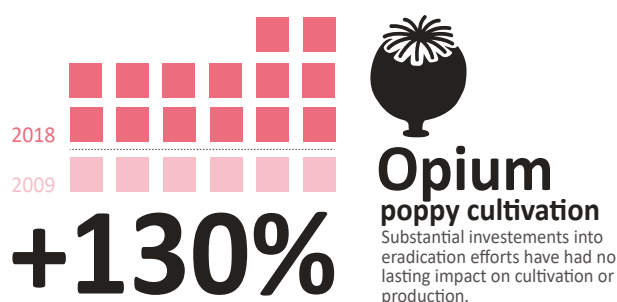
The latest data from the UNODC shows no reduction in the scale of cultivation of opium, coca and cannabis between 2009 and 2018 (see [Table 1](#)). Since 2009, cultivation has in fact increased for all these plants. According to data submitted by UN member states to the UNODC between 2009⁶⁹ and 2018,⁷⁰ the global illegal cultivation of opium poppy has increased by 130%. This is mainly due to a surge in cultivation in Afghanistan, where poppy cultivation increased from 123,000 hectares (with potential opium production at 6,900 tons) in 2009 to 328,000 hectares in 2017 (with potential opium production at 9,000 tons). Similarly, the global cultivation of the coca bush rose by 34% over the period 2009-2016. As for cannabis, while the World Drug Report estimated that between 200,000 and 641,800 hectares of the plant were being

Table 1. Global cultivation of opium poppy, coca bush and cannabis plant 2009-2018

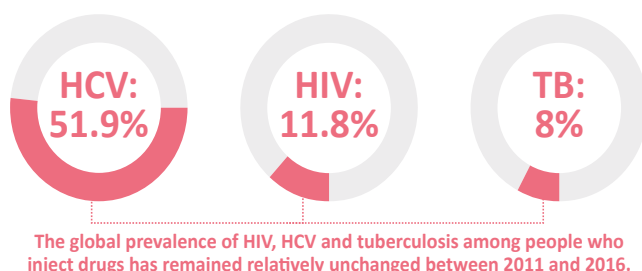
Global cultivation	2009	Latest estimates	Change since 2009
Opium poppy	181,373 ha ⁷¹	418,000 ha (2017) ⁷²	+ 130%
Metric tons of potential opium production	7,754 tons ⁷³	10,500 tons (2017) ⁷⁴	+ 35%
Coca bush	158,800 ha ⁷⁵	213,000 ha (2016) ⁷⁶	+ 34%
Metric tons of potential cocaine production	976.5 tons (range: 842 to 1,111) ⁷⁷	1,410 tons (2016) ⁷⁸	+ 44%
Cannabis	200,000-641,000 ha ⁷⁹	No recent estimate available from the UNODC	Unknown

Progress against Art. 36 2009 Political Declaration

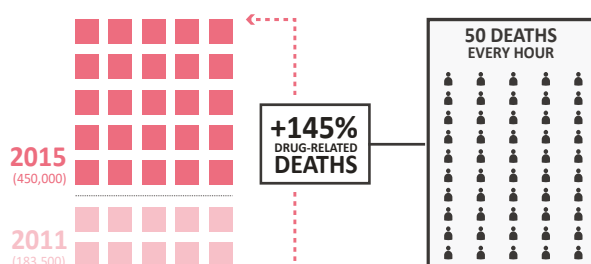
Illicit cultivation



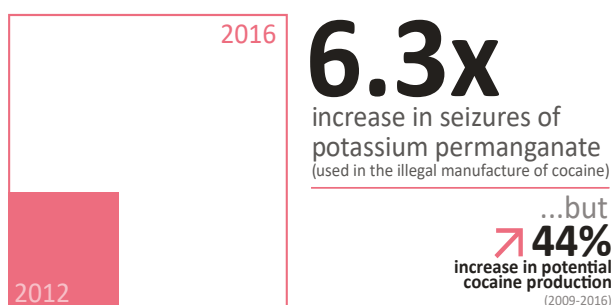
Drug-related health risks



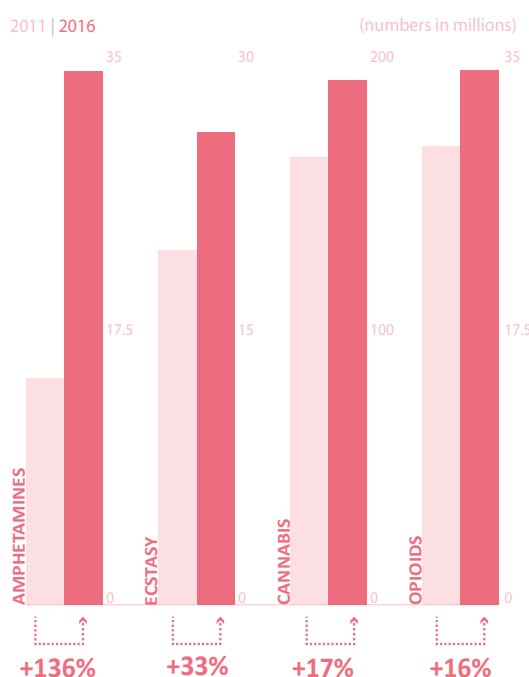
Drug-related deaths



Drug-related health risks



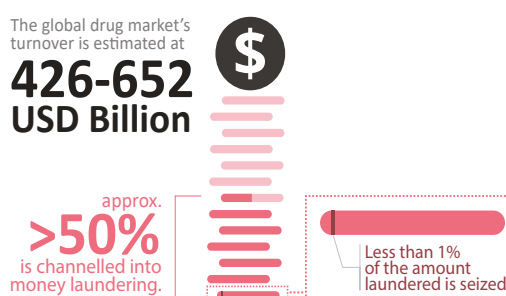
Illicit demand



New psychoactive substances



Money laundering



Box 2 Global estimates on drug demand and supply: Methodology and gaps in data collection

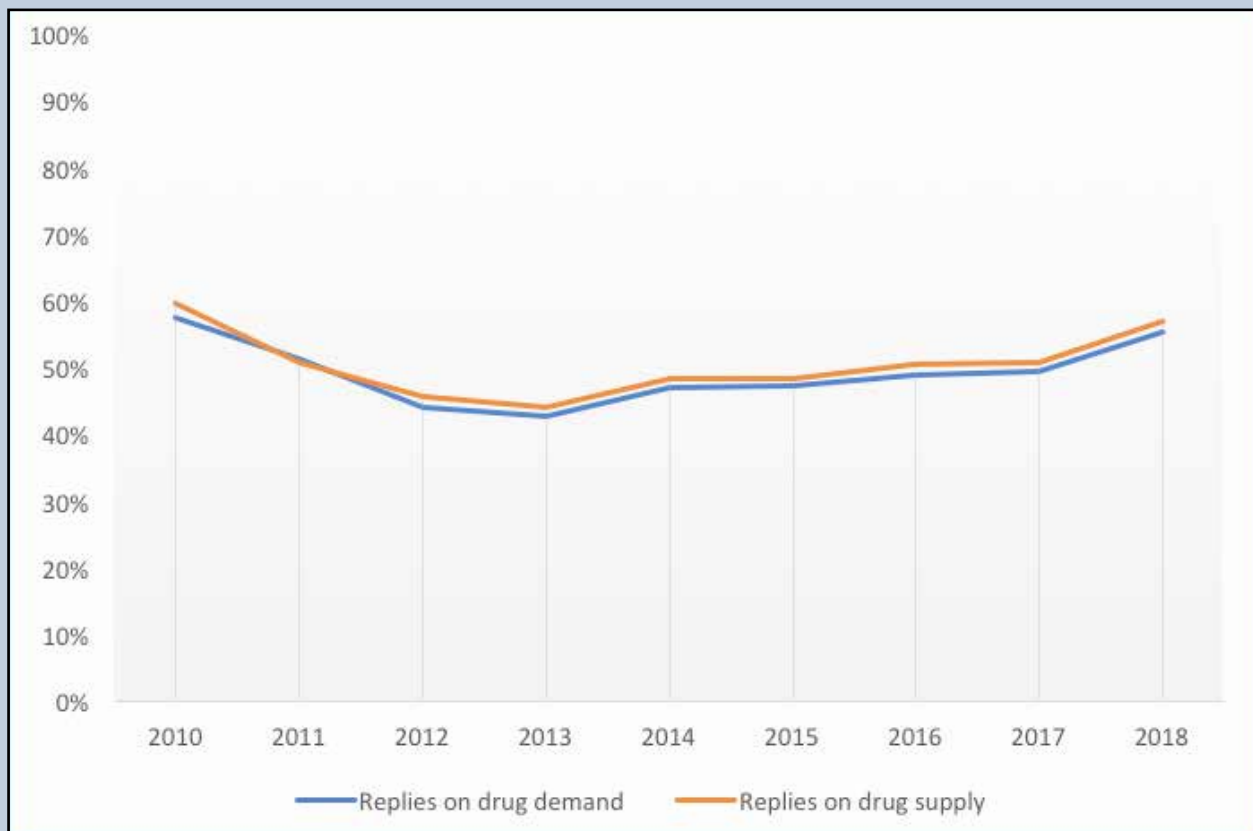
Across the period 2009 to 2018, the UNODC has attempted to improve the data upon which it bases its annual World Drug Reports. However, these reports continue to be based essentially on data assembled from completed ARQs,⁸⁰ which countries are mandated to provide to the UNODC secretariat each year. Although the ARQ was revised in 2010, just a year following the adoption of the Political Declaration, the secretariat regularly acknowledges the gaps, irregularities and varying quality of data received from this mechanism.⁸¹

For example, in the 2018 World Drug Report (which refers to data from 2016) out of 199 respondents, the UNODC received 110 replies to ARQ part 3 ('Extent and patterns of drug use') and 113 replies to ARQ part 4 ('Extent and patterns of cultivation, manufacture and trafficking') (see Figure 2). The geographical distribution of responses is another issue of concern. While 87% of countries responded in Europe and 77% in Asia, only 57% responded in the Americas, 31%

in Africa and, finally, only 2 out of 16 countries in Oceania. These issues severely impact upon the reliability, quality and comparability of the UNODC's core data.⁸² In order to fill the gaps in data collection from the ARQ, the UNODC uses a number of additional data sources, including information provided by governments via official communications with the UNODC, official national publications, as well as data from the Heads of National Law Enforcement Agencies, data published by international and regional organisations such as Interpol, the World Customs Organization, the European Monitoring Centre on Drugs and Drug Addiction, and the OAS Inter-American Drug Abuse Control Commission (CICAD).

The UNODC's biennial reports on the implementation of the 2009 Political Declaration and Plan of Action, published in 2012, 2014, 2016 and 2018, also rely upon the ARQ data submitted by governments. These analyse the progress – or

Figure 2. Response rate by member states to the ARQ on drug demand and supply for the World Drug Reports produced between 2010 (data from 2008-9) and 2018 (data from 2016)⁸³



Continued on next page

otherwise – made toward the objectives of the 2009 Political Declaration and Plan of Action, and are therefore likewise affected by the gaps and lack in quality of data. The latest report published in 2018 deploys data gathered between 2010 and 2016, taken from parts 1 ‘Legislative and institutional framework’ and 2 ‘Comprehensive approach to drug demand reduction and supply’ of the ARQ. For part 2, the UNODC notes that only about 40% of member states supplied data for use in the analysis of certain trends, such as activities related to supply reduction. Regions including Sub-Saharan Africa, Oceania and the Caribbean are heavily underrepresented in the sample, with only about 10% or less of member states in those regions responding consistently to parts 1 and 2 of the ARQ.⁸⁴ A new round of consultations is currently underway to simplify and streamline the ARQ, with a view to adapt

the ARQ to new realities but also to increase its response rate.⁸⁵

Bearing in mind the multiple methodological complexities and gaps in available data, this section of the Shadow Report heavily relies on UNODC data, but also considers additional sources of information from other UN agencies, government reports and civil society findings. Furthermore, in 2013, the UNODC reported that data from 2011 represented improved ‘estimation methods applied and increased global coverage’ of drug use from previous years, as well as ‘an improved availability of more reliable data, which allows for setting a new baseline for global estimates on injecting drug use and HIV among people who inject drugs’.⁸⁶ For drug use and drug-related harms, this report therefore relies on baseline estimates from 2011, rather than on those for 2009.⁸⁷

cultivated in 2009, no global estimates were provided in 2018, although the UNODC concluded that cannabis cultivation was reported in 145 countries in the period 2010–2016, ‘representing 94 per cent of the world’s total population’.⁸⁸

It is important to note that, with the exception of Bolivia, which has implemented a sophisticated coca monitoring system carried out with the support of the European Union and local communities, these cultivation figures should be considered as very rough estimates, as evidenced in the often vastly different reporting between the UN and the US government.⁸⁹ They do, however, provide a useful measure for evaluating trends over time.

1.2 The illicit demand for narcotic drugs and psychotropic substances, and drug-related health and social risks

Here again, UNODC data for 2011⁹⁰ and 2016⁹¹ show no significant progress either on reducing demand, or on reducing drug-related health and social risks (see Table 2). The overall number of people aged 15–64 who used drugs at least once in 2016 is estimated at 275 million, representing an increase by 31% on the 2011 numbers. It should be noted that over the same period, the overall world population increased by only 6%.⁹² The UNODC reported a reduction in the numbers of people who inject drugs from 14

million in 2011 to 10.6 million in 2016 – although the 2018 World Drug Report also notes that ‘This estimate is based on the most recent and highest quality information currently available to UNODC. It does not imply that there has been a change in the global number of PWID compared with those published in previous editions of the World Drug Report’. The main drug of choice remains cannabis, with 192.2 million (increase by 17% since 2011), followed by opioids (increase by 16% since 2011) and amphetamines (with a major increase by 136% since 2011).

Regarding drug-related health and social risks, the UNODC estimates that the global prevalence of HIV, hepatitis C and tuberculosis among people who inject drugs have remained high but stable, between 2011 and 2018 – although this does not reflect possible increases or decreases within countries or regions, especially where data is scarce or of poor quality. According to the latest data, globally 11.8% of people who inject drugs are living with HIV (compared to 11% in 2011), and 51.9% are infected by hepatitis C (compared to 51% in 2011), while tuberculosis prevalence is at 8% (a slight decrease from the 2011 estimate at 8.4%). The number of drug-related deaths has surged by 145% since 2011, from 183,500 deaths in 2011⁹³ to 450,000 recorded deaths in 2015.⁹⁴ Of those, 33 to 50% are caused by fatal overdose deaths.⁹⁵

Table 2. Global estimates of people who use drugs, 2011 and 2016

Global estimates of people who use drugs	2011 ⁹⁶	Latest estimates (2016) ⁹⁷	Change since 2009
Total number of people who use drugs	210 million (range: 149-272 million)	275 million (range: 204-346 million)	+ 31%
Total number of people who inject drugs	14 million	10.6 million*	- 24%*
Total number of 'problem drug users'	27 million (range: 15-39 million)	30.5 million (range: 16.7-44.4 million)	+ 13%
Number of people using cannabis	164 million (range: 125-203 million)	192.2 million (range: 165.8-234.1 million)	+ 17%
Number of people using opioids	29.5 million (range: 24-35 million)	34.3 million	+ 16%
Number of people using ecstasy	19.5 million (range: 11-28 million)	26 million	+ 33%
Number of people using cocaine	17.5 million (range: 14-21 million)	18.2 million	+ 4%
Number of people using opiates	16.5 million (range: 12-21 million)	19.4 million	+ 18%
Number of people using amphetamines and prescription stimulants	14.5 million (range: 14-15 million)	34.2 million	+ 136%

* This change can most likely be explained by methodological differences in data collection between 2011 and 2016 rather than by a reduction in the number of people who inject drugs, as noted in the 2018 World Drug Report.

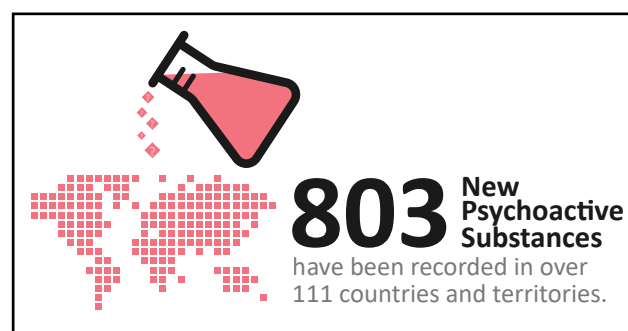
1.3 The illicit production, manufacture, marketing and distribution of, and trafficking in, psychotropic substances, including synthetic drugs

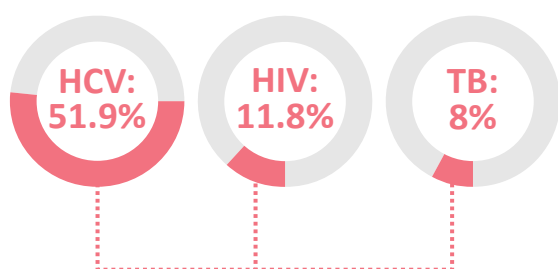
Since 2009, the market for synthetic drugs – referred to in the UN conventions as 'psychotropic substances' – has become more complex and diversified than ever, and shows no signs of disappearing. The 2018 World Drug Report found a persisting production and use of methamphetamine in North America and East and South East Asia, an expanding amphetamine market (both trafficking and use) from the well-established markets of the Near and Middle East/South West Asia to North African countries, and a surge in synthetic manufacture and consumption in South Asia.⁹⁸ In 2015, the UNODC also reported an increase in methamphetamine production in West Africa, although this still constitutes a small share of overall global production of the substance.⁹⁹ The market for crystal methamphetamine was also reportedly on the rise in North America, East and South East Asia and Oceania, with a purer substance (crystals) than the traditional tablet form. Further, despite efforts to dismantle illegal manufacturing laboratories of MDMA (ecstasy) and to address

trafficking of this substance, MDMA consumption is rising in Europe and Oceania.¹⁰⁰ The increasing use of new technologies, in particular sales via the dark net, is posing additional challenges.¹⁰¹

In addition to the expanding market for traditional synthetic drugs, the past decade has seen the emergence of hundreds of new psychoactive substances (NPS). In 2018, the UNODC reported that 'the range of psychoactive substances available on the market has never been greater', adding that 'From 2009 to 2017, 111 countries and territories reported a cumulative total of 803 individual NPS'.¹⁰²

Another issue for this target relates to the non-medical use of prescription drugs. Already in its 2011 World Drug Report (corresponding to data from 2009), the UNODC had characterised the 'non-medical use of prescription drugs' as 'a growing health



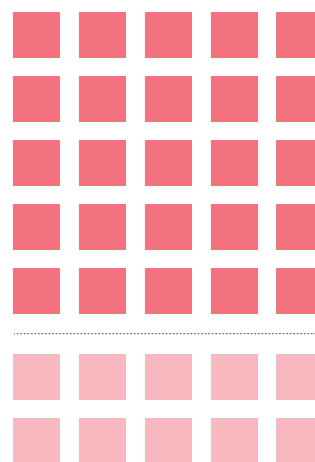


The global prevalence of HIV, HCV and tuberculosis among people who inject drugs has remained relatively unchanged between 2011 and 2016.

+145%
drug-related
deaths

2015
(450,000)

2011
(183,500)



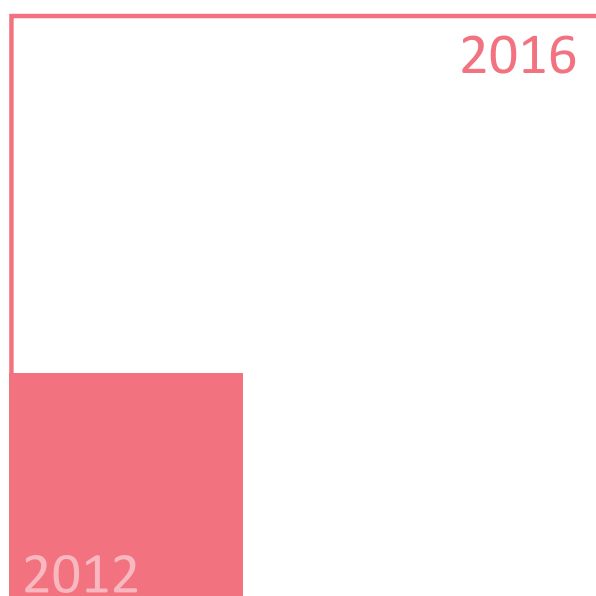
Credit: Juan Fernandez Ochoa, IDPC

problem in a number of developed and developing countries'. In 2018, the situation was described as having 'reached epidemic proportions in parts of the world', in particular in North America where it has contributed to the opioid overdose crisis that has caused thousands of deaths over the past few years (see [Box 4](#)). Although 'global estimates of the non-medical use of prescription drugs are not available', the latest data led the UNODC to conclude that it 'remains quite widespread', with the use of benzodiazepines being the most common substance used in most countries.¹⁰³

1.4 The diversion of and illicit trafficking in precursors

Precursors are the 'chemical substances that become incorporated, at the molecular level, into a narcotic drug or psychotropic substance during the

manufacturing process'.¹⁰⁴ They are controlled under Article 12 of the 1988 Convention, which is policed by the INCB. The monitoring of precursor chemicals remains at the core of member states' drug supply reduction activities.¹⁰⁵ During the period 2010-2016, 90% of ARQ respondents reported compiling lists of national companies authorised to manufacture, distribute and trade in precursors. Member states also adopted new measures to curb the diversion of, and illegal trafficking in, precursors, including the dissemination of lists of controlled substances to companies, the establishment of codes of conduct and guidelines for operators, and the adoption of legislation requiring companies to report the transactions of controlled substances. Meanwhile, the proportion of member states engaging in monitoring precursor chemicals decreased slightly between 2010 and 2016 from 100% to 97%. The proportion of member states having systems in place to allow



6.3x

increase in seizures of
potassium permanganate
(used in the illegal manufacture of cocaine)

...but
44%
increase in potential
cocaine production
(2009-2016)

Credit: Juan Fernandez Ochoa, IDPC

for post-seizure investigations into precursor control decreased between 2010 and 2016, falling from 94% to 77%.¹⁰⁶

At international level, the proportion of countries using the INCB's Pre-Expert Notification Online (PEN Online) system – which enables easy online exchange of information between member states on shipments of chemicals and provides the ability to raise alerts to stop suspect shipments before they reach illegal drug manufacturers – increased from 86% in 2010 to 98% in 2016.¹⁰⁷ In the same period, around half of member states also reported taking steps to address the use of substances not under international control, as well as to target substitute chemicals for the manufacture of precursors used for the manufacture of heroin, cocaine or ATS.¹⁰⁸

With regards to NPS, the challenge of controlling these substances begins with the identification of their precursor chemicals, and the methods used in their manufacture.¹⁰⁹ The first NPS precursors to be internationally controlled were 4-anilino-N-phenethylpiperidine (ANPP) and N-Phenethyl-4-piperidinone (NPP), two precursors of fentanyl, which were scheduled into Table 1 of the 1988 Convention in October 2017.¹¹⁰ This brought the total of internationally controlled precursor substances to 26.

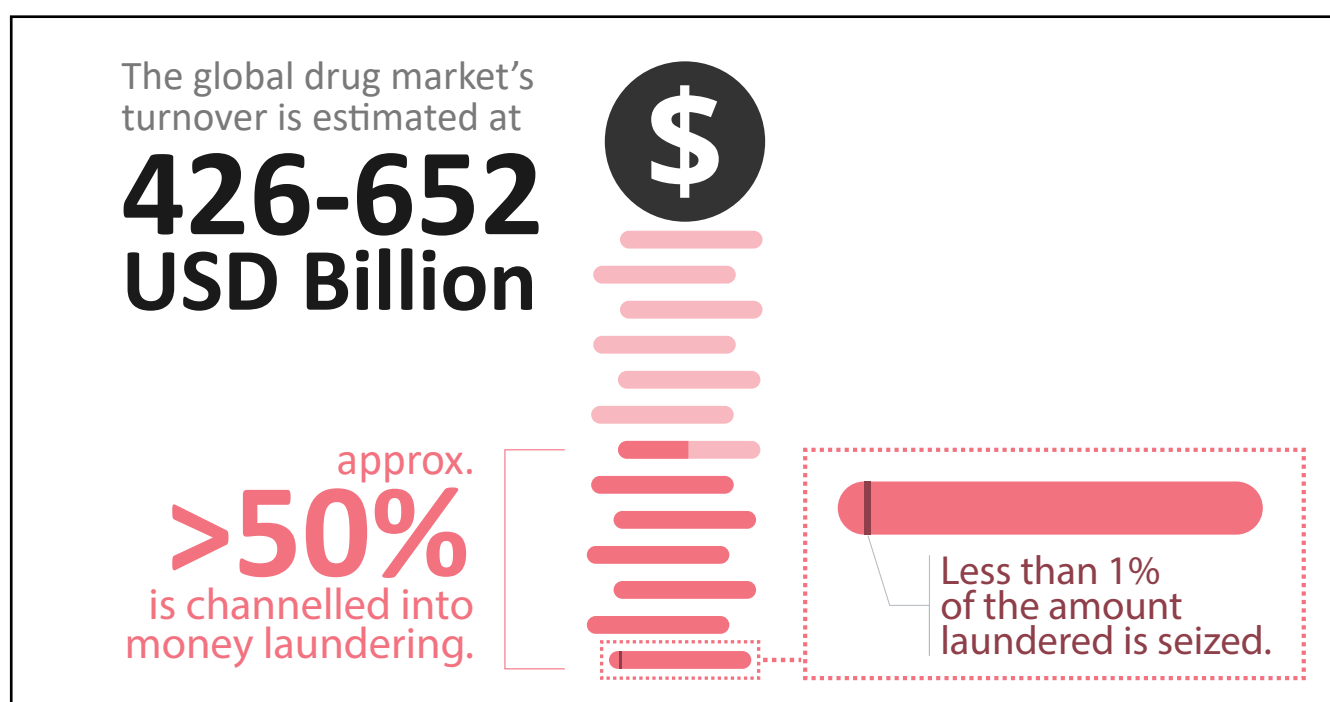
Despite these drug control efforts, however, the INCB reported that the use and number of precursors used in illegal production had increased in the past five years. Although there are major gaps in available data reported to the INCB on seizures of precursors,¹¹¹ the Board reported a large increase in the seizure of acetic anhydride (used in the illegal manufacture of heroin)

from 89,657 litres in 2012 to 135,184 litres in 2016.¹¹² Similarly, the seizures of potassium permanganate (used in the illegal manufacture of cocaine) increased from 92,702 kg in 2012 to 585,072 kg in 2016. Regardless of the increase in seizures, as mentioned above the production of cocaine has increased by 44% between 2009 and 2016 (see Table 1).

1.5 Money-laundering related to illicit drugs

While efforts have been made nationally to adopt new laws and regulations, and globally through regional and international cooperation mechanisms to counter money-laundering associated to the illegal drug market (see [Section 2.2.3](#) below), little impact has been recorded on the scale of money-laundering between 2009 and 2018 – a UNODC study in 2011 estimated that less than 1% of the total amount being laundered is seized.¹¹³

In 2009, criminal proceedings from the illegal drug market amounted to an estimated 3.6% of the global GDP, 2.7% of which was being laundered, representing US\$ 1.6 trillion.¹¹⁴ The UNODC's latest estimates, released in 2017 and referring to data from 2014, point to the fact that the amount of money laundered globally each year represents 2 to 5% of global GDP, that is, between US\$ 800 million and 2 trillion.¹¹⁵ The proceeds of drug sales 'accounted for more than one quarter of overall revenues of transnational organized crime groups in 2014'. 'In recent years', the UNODC continues, 'drug-related income seems to have represented the second largest



Credit: Juan Fernandez Ochoa, IDPC

source of income – after counterfeiting of a broad range of goods – of transnational organized crime groups at the global level.¹¹⁶ Today, the global drug market is estimated to turnover between US\$ 426 and 652 billion.¹¹⁷ Of this, the UNODC estimates that ‘well over half of the gross profits generated...are channelled into money-laundering’.¹¹⁸

At regional level, similar trends have been observed. In Europe, the illegal drug market is valued at approximately 28.3 billion euros a year.¹¹⁹ A number of anti-money-laundering regulations were adopted by the EU over the past 10 years, with over US\$ 20 billion spent by banks each year to run a complex

compliance regime. Despite these efforts, according to Europol, money launderers are running billions of illegal drug and other criminal profits through the European banking system with a 99% success rate – with only 1% of criminal assets seized each year in the EU.¹²⁰ Similarly, West Africa has been greatly affected by the illegal drug market, corruption and money-laundering over the past 20 years. Despite efforts to tackle these issues, the number of court rulings on money-laundering is reportedly very low and, according to the Inter-Governmental Action Group Against Money-laundering in West-Africa, ‘has not yielded the expected result’.¹²¹

2 Assessing progress made towards the 2009 Plan of Action against the broader priorities of the United Nations

Since the adoption of the UN Charter in 1945,¹²² the UN has aimed to maintain international peace and security, protect human rights, deliver humanitarian aid, promote sustainable development and uphold international law.¹²³ It is against three of these overarching UN priorities – protecting human rights, maintaining peace and security and advancing development – that Section 2 evaluates progress made against selected actions to which member states unanimously committed themselves in the 2009 Political Declaration and Plan of Action on drug control. Relevant actions are highlighted at the top of each sub-section in a text box.

2.1 Protecting human rights

'One of the shared elements to all declarations, action plans and resolutions that underline the principle of a comprehensive, integrated and balanced approach to addressing the world drug problem is the commitment to ensuring compliance with human rights norms', INCB, June 2018¹²⁴

The protection and promotion of human rights is a key purpose, as well as a guiding principle, of the UN and its founding Charter.¹²⁵ In 1948, the Universal Declaration of Human Rights¹²⁶ brought human rights into the realm of international law, with all UN bodies and entities – including the Vienna-based drug control bodies – being bound by the obligation to respect, protect and fulfil human rights and fundamental freedoms. Since then, a normative and institutional framework for the promotion and protection of human rights has been developed through the adoption of several binding human rights treaties.

The 2009 Political Declaration itself reaffirms its 'unwavering commitment to ensure that all aspects of demand reduction, supply reduction and international cooperation are addressed in full conformity with the purposes and principles of the Charter of the United Nations, international law and the Universal Declaration of Human Rights' (paragraph 1). A similar paragraph was included in the preamble of the UNGASS Outcome Document,¹²⁷ alongside an entire section dedicated to human rights.

In recent years, increasing visibility has been given to the impacts of drug control on human rights, in particular with the adoption of the first ever Human Rights Council resolution on human rights and drug policy in 2015¹²⁸ which resulted in a comprehensive analysis of the issue by the Office of the High Commissioner for Human Rights (OHCHR) a few months later.¹²⁹ A second resolution was approved at the Human Rights Council in March 2018, mandating the OHCHR to draft a report aiming to contribute to the implementation of the UNGASS Outcome Document from a human rights perspective.¹³⁰

This section will assess the impacts of drug policies, strategies and programmes on the protection of human rights, in particular the right to health, the right to enjoy the benefits of scientific research, the right to life, the right to be free from torture and other cruel, inhuman and degrading treatment or punishment, the right to liberty and to be free from arbitrary detention, the right to a fair trial and due process, the rights of indigenous people, and the right to be free from discrimination.

2.1.1 The right to highest attainable standard of health

The right to the highest attainable standard of physical and mental health conducive to living a life in dignity (thereafter referred to as 'the right to health') is a human right which applies equally to all without discrimination. It is enshrined in a number of human rights treaties, including Article 12 of the International Covenant on Economic, Social and Cultural Rights¹³¹ (as well as General Comment No. 20 on non-discrimination in economic, social and cultural rights¹³² and General Comment No. 22 on sexual and reproductive health¹³³), Article 24 of the Convention on the Rights of the Child,¹³⁴ Article 12 of the Convention on the Elimination of All Forms of Discrimination against Women¹³⁵ and Article 5 of the International Convention on the Elimination of All Forms of Racial Discrimination.¹³⁶

The right to health includes the rights to control one's health and body, and to be free from non-consensual medical treatment and experimentation

Assessing progress on Human rights

Death penalty

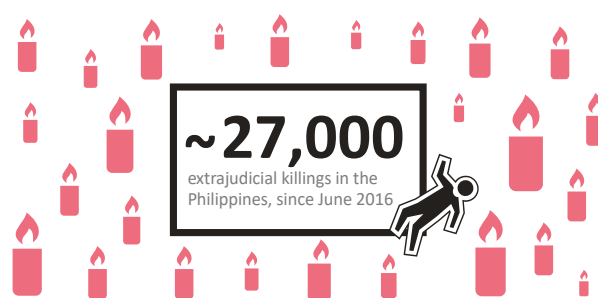
3,940

people have been executed for drug offences over the past decade

33 jurisdictions retain the death penalty for drug-related crimes



Extrajudicial killings



Access to harm reduction



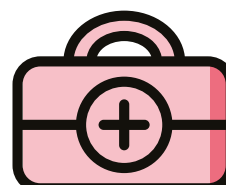
Only 1 in 100 people who inject drugs lives in a country with adequate coverage of both NSP and OST

Health in prisons



HIV, HCV & TB prevalence in prison
2x - 10x
higher than among the general population

Overdose response



only **8%** United States counties implement overdose education and naloxone distribution programmes

Decriminalisation

26

 countries have adopted a model of decriminalisation

to facilitate access to health services, reduce stigma and reduce prison overcrowding.



Access to essential medicines

92%
of the global supply of morphine is used by 17% of the world population.



75% of the world remain without access to proper pain relief treatment.

Incarceration

1 in 5

 prisoners worldwide are incarcerated for drug offences


In some parts of the world, over **80%** of women incarcerated are serving sentences for drug-related offences.

~83%
serve sentences for drug possession for personal use



Torture and cruel punishment



can also amount to acts of torture or cruel treatment.

which may amount to torture. In accordance with the obligation to uphold the right to health, member states must ensure that healthcare goods, services and information are available, accessible, affordable, acceptable and of good quality.¹³⁷ States have an immediate obligation to take steps to progressively realise the right to health to the maximum of their available resources, and should not take retrogressive measures which may result in reducing or preventing protections of the right to health.

Ensuring access to evidence-based drug prevention

2009 Political Declaration and Plan of Action

Action 2(g): ‘Develop and implement, in cooperation with international and regional agencies, a sound and long-term advocacy strategy, including harnessing the power of communication media, aimed at reducing discrimination that may be associated with substance abuse, promoting the concept of drug dependence as a multifactorial health and social problem and raising awareness, where appropriate, of interventions based on scientific evidence that are both effective and cost-effective’

Drug prevention programmes have historically consisted of mass media campaigns focusing on ‘just say no’ messaging and scare tactics to deter people from using drugs. Both the UNODC¹³⁸ and national policy makers have used this approach. In the USA, for example, the Montana Meth Project used slogans like ‘Not even once’, mistakenly implying that methamphetamine use instantly leads to dependence, and portraying people who use methamphetamines as violent, engaging in risky and promiscuous behaviour, or induced into a ‘zombie like’ status.¹³⁹ In 2011, Romania launched a large-scale government-funded campaign to tackle the recent surge in NPS use, comparing people who use drugs with cows eating grass.¹⁴⁰ Systematic reviews of these mass media campaigns found that they have been ineffective at curbing the levels of drug use (which they had purportedly claimed to do), and may have exacerbated the social stigmatisation and demonisation of people who use drugs,¹⁴¹ exacerbating social exclusion, discrimination, violence and creating barriers to service and healthcare provision.

Similar campaigns have been developed to curb illegal cultivation – some of which have been found to be stigmatising towards indigenous groups. For instance, in 2008 the National Drug Commission of

Colombia launched a prevention campaign called ‘No cultives la mata que mata’¹⁴² – ‘Don’t grow the plant that kills’ – to dissuade people from cultivating, trafficking and using coca, cannabis and opium. The indigenous group Coca Nasa – a micro-firm created to protect the rights of coca farmers – brought an official complaint against the campaign. This resulted in a Supreme Court decision in 2010 which found that the campaign infringed upon the rights of Coca Nasa and indigenous groups within Colombia to grow and use coca for traditional purposes.¹⁴³

In 2018, the UNODC concluded that most prevention interventions had reported ‘little or no efficacy’.¹⁴⁴ Yet, based on ARQ responses, 57% of member states continue to use media campaigns, 63% use information sharing and 15% use ‘vocational training and income generation’ programmes. On the other side of the spectrum, only 21% of UN member states use family and parenting skills training and just 17% use screening and brief interventions, despite evidence of effectiveness for both interventions.¹⁴⁵

Worryingly, the UNODC also reported no improvement since 2009 in the trend to evaluate prevention interventions, with most evaluations using process indicators, and ‘only a small number focusing on outcomes, and even fewer on impact’.¹⁴⁶ The progress made towards ensuring that interventions are based on scientific evidence of effectiveness has therefore been limited since the adoption of the Political Declaration. In an effort to ‘guide policy-makers worldwide to develop programmes, policies and systems that are a truly effective investment’, the UNODC launched a set of ‘International standards on drug use prevention’ in 2015.¹⁴⁷ However, no follow-up study or evaluation on how the standards have been taken forward by member states has been conducted to date.



Credit: Private

2009 Political Declaration and Plan of Action

Action 4(i): ‘Strengthen their efforts aimed at reducing the adverse consequences of drug abuse for individuals and society as a whole, taking into consideration not only the prevention of related infectious diseases, such as HIV, hepatitis B and C and tuberculosis, but also all other health consequences, such as overdose, workplace and traffic accidents and somatic and psychiatric disorders, and social consequences, such as family problems, the effects of drug markets in communities and crime’

Action 10(b): ‘Ensure, where appropriate, the sufficient availability of substances for medication-assisted therapy, including those within the scope of control under the international drug control conventions, as part of a comprehensive package of services for the treatment of drug dependence’

Action 28(c): ‘Develop prevention and treatment programmes tailored to the specific characteristics of the phenomenon of amphetamine-type stimulants as key elements in any relevant strategy to reduce demand and minimize health risks’

Harm reduction refers to policies, programmes and practices that aim primarily to reduce the negative health, social and economic risks and harms associated with drug use without necessarily reducing drug consumption. Harm reduction benefits people who use drugs, their families and the community.¹⁴⁸ Harm reduction is needed for all types of drugs (e.g. heroin, cocaine, cannabis, ATS, NPS, etc.) and all forms of use (e.g. smoking, injecting, snorting, etc.). Although not specifically mentioned by name, this evidence-based approach is implicitly recognised within Article 36 of the Political Declaration and in two specific actions (Action 4(i) and 28(c)), and several key harm reduction interventions were included in the 2016 UNGASS Outcome Document (paragraphs 1.o and 1.m)¹⁴⁹ for the first time. Harm reduction measures have also been recognised as essential for the realisation of the right to health by the UN General Assembly,¹⁵⁰ the Human Rights Council,¹⁵¹ the Committee on Economic, Social and Cultural Rights,¹⁵² the Committee on the Rights of the Child,¹⁵³ the Committee on the Elimination of All Forms of Discriminations against Women,¹⁵⁴ the Special Rapporteurs on the right to health¹⁵⁵ and on the prevention of torture,¹⁵⁶ as well as the OHCHR.¹⁵⁷

Box 3 CND resolutions related to harm reduction since 2009

Resolution 61/4. Promoting measures for the prevention of mother-to-child transmission of HIV, hepatitis B and C and syphilis among women who use drugs (2018)

Resolution 61/11. Promoting non-stigmatizing attitudes to ensure the availability of, access to and delivery of health, care and social services for drug users (2018)

Resolution 60/8. Promoting measures to prevent HIV and other blood-borne diseases associated with the use of drugs, and increasing financing for the global HIV/AIDS response and for drug use prevention and other drug demand reduction measures (2017)

Resolution 56/6. Intensifying the efforts to achieve the targets of the 2011 Political Declaration on HIV and AIDS among people who use drugs, in particular the target to reduce HIV transmission among people who inject drugs by 50 per cent by 2015 (2013)

Resolution 55/7. Promoting measures to prevent drug overdose, in particular opioid overdose (2012)

Resolution 54/13. Achieving zero new infections of HIV among injecting and other drug users (2011)

Resolution 53/9. Achieving universal access to prevention, treatment, care and support for drug users and people living with or affected by HIV (2010)

The effectiveness of harm reduction measures in protecting the health of people who use drugs is well documented. Since 2009, progress has been made to recognise and promote the nine interventions included in the Technical guide released by the WHO, UNODC and UNAIDS in 2012 on HIV prevention interventions among people who inject drugs, including needle and syringe programmes (NSPs) and opioid substitution therapy (OST).¹⁵⁸ The number of countries with an explicit reference to harm reduction in national policy documentation increased from 71 in 2008 to 88 in 2016.¹⁵⁹ Since 2008, the number of countries providing NSPs, OST, drug consumption rooms and take-home

Table 3. Countries delivering key harm reduction interventions, 2008-present

Harm reduction services	Number of countries with services in operation in 2008-2010	Number of countries with services in operation in 2017-2018	Change since 2008
NSP	82 countries (2008) ¹⁶⁰	93 countries ¹⁶¹	11 more countries
OST	70 countries (2008) ¹⁶²	86 countries ¹⁶³	16 more countries
Drug consumption rooms	8 countries (90 rooms) (2009) ¹⁶⁴	10 countries (118 rooms) ¹⁶⁵	2 more countries
Take-home naloxone distribution	14 countries (2010) ¹⁶⁶	15 countries ¹⁶⁷	1 more country
Drug checking	Unknown	18 countries ¹⁶⁸	Unknown
Heroin-assisted therapy	Unknown	7 countries ¹⁶⁹	Unknown

naloxone (an opioid/opiate overdose antidote) has also increased (see [Table 4](#)). Globally, the number of drug consumption rooms has increased over the period 2008-2017, from 90 to 118 rooms, as Canada opened 25 new facilities over the past two years, spurred in part by the worrying increase in opioid overdose deaths in the country (see [Box 4](#)).¹⁷⁰ Between 2014 and 2016, the UNODC also reported an increase in the coverage of antiretroviral therapy, condom distribution, targeted information and education, hepatitis B and C prevention, diagnosis and treatment, as well as tuberculosis prevention, diagnosis and treatment.¹⁷¹

Despite such progress, significant challenges remain. At global level, only seven CND resolutions related to specific harm reduction were adopted since 2009 (i.e. 5% of all resolutions adopted, see [Box 3](#)), but the term ‘harm reduction’ has not yet been mentioned in any CND resolution or UNGASS declaration on drugs – although the term is enshrined in the Political Declarations on HIV and AIDS adopted in 2006,¹⁷² 2011¹⁷³ and 2016,¹⁷⁴ and used widely across the UN agencies. Most recognised harm reduction interventions at the UN relate to drug injecting¹⁷⁵ (see [Box 4](#)), with limited attention given to other methods of use, such as smoking and snorting, which require their own modes of harm reduction. This is despite the fact that the UNODC reported a 136% increase in ATS use since 2009 – placing this category of drugs second only to cannabis¹⁷⁶ (see [Table 2](#)). Although action 28(c) promotes ‘prevention and treatment programmes’ to ‘reduce demand and minimize health risks’ for ATS use, these programmes remain severely limited, and few efforts have been made to evaluate the level of coverage for harm reduction interventions among

people who use ATS. To date, guidance from the UN on ATS use only consists of a WHO series of technical briefs published in 2011.¹⁷⁷ The publication of a conference room paper on stimulant harm reduction at the 61st session of the CND in March 2018 was a positive step in this regard.¹⁷⁸ In this context, civil society research and interventions have been instrumental in responding to non-injecting ATS use. ATS harm reduction interventions have included:

- Measures seeking to improve personal hygiene and nutrition, for example making water, fruits, toothpaste and toothbrushes available in low-thresholds drop-in centres, sharing of information on how to improve diets and getting adequate rest¹⁷⁹
- Information on how to inject or smoke more safely, and the promotion of less harmful routes of drug use (e.g. smoking vs. injecting, although long-term smoking may also result in health harms) with the provision of smoking paraphernalia to reduce harms (e.g. in Canada, Italy, the Netherlands and Switzerland)
- Drug checking services, allowing people to ascertain the content, purity and strength of their drug to reduce risks of overdoses and undesired or unexpected effects from ingesting toxic and/or dangerous contaminants. Around 30 drug checking services (some officially recognised by governments, others operating informally) are available in 18 countries: Australia, Austria, Belgium, Canada, Colombia, France, Italy, Luxembourg, Mexico, the Netherlands, New Zealand, Portugal, Slovenia, Spain, Switzerland, the UK, Uruguay and the USA¹⁸⁰
- Housing first programmes and the provision of basic healthcare, food distribution and

employment services to reduce marginalisation and associated harms (e.g. in Brazil, Canada and Switzerland)

- Peer-led information sharing, reviews and feedback on drug purchases and use in online forums, and harm reduction advice on the dark net (e.g. community groups in Eastern Europe and Central Asia promoting HIV testing on the dark net).

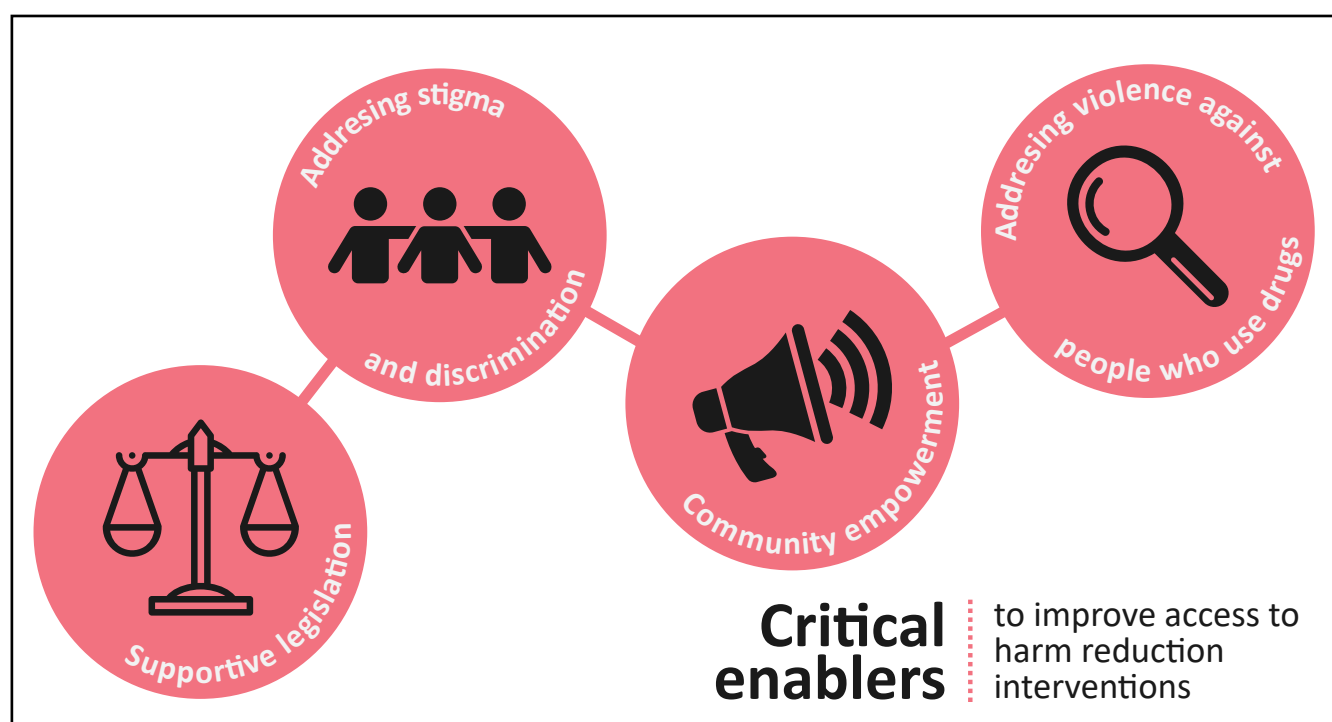
Even for the more ‘traditional’ harm reduction services, access remains a key issue with no availability of OST, NSPs or naloxone in about 100 countries. Even in countries where these services are available, coverage for the core interventions promoted in the UN Technical Guide remains ‘too low to be effective’,¹⁸¹ with high coverage for NSPs in only nine countries, and OST only in 20 countries (see Figure 3). A 2017 study also found that less than 1% of people who inject drugs live in countries with high coverage of both NSPs and OST.¹⁸²

Another major challenge remains the lack of funding allocated to harm reduction interventions. UNAIDS estimates that US\$ 1.5 billion is required each year by 2020 to fund HIV prevention among people who inject drugs.¹⁸³ However, only US\$ 188 million was allocated to harm reduction in 2016 – the same amount (inflation adjusted) as in 2007, and just 13% of what is needed.¹⁸⁴ It is also estimated that international donor funding – which accounts for two thirds of all harm reduction funding – fell by 24% between 2007 and 2016.¹⁸⁵ Furthermore, while the funding gap for the broader HIV response in low-

and middle-income countries is reported to be 20%, it should be noted that the gap is close to 90% for harm reduction.¹⁸⁶

The urgent need to address the funding gap for harm reduction was recognised at the CND in 2017, with the adoption of Resolution 60/8 ‘Promoting measures to prevent HIV and other blood-borne diseases associated with the use of drugs, and increasing financing for the global HIV/AIDS response and for drug use prevention and other drug demand reduction measures.’¹⁸⁷ With indications of reduced international donor funding for harm reduction, and limited domestic investment in harm reduction approaches within HIV budgets, civil society has called upon governments to critically evaluate their drug policy investments and consider redirecting a small proportion of funds from law enforcement to health and harm reduction responses.¹⁸⁸ Indeed, Harm Reduction International estimated that redirecting just 10% of drug law enforcement funding towards harm reduction would cover harm reduction needs in the community and in prison¹⁸⁹ – where coverage remains particularly poor ([see below](#)).

Furthermore, there remain significant legislative, political and technical barriers hampering access to harm reduction. The WHO ‘Consolidated guidelines on HIV prevention, diagnosis, treatment and care for key populations’, first published in 2014 and revised in 2016, identified four ‘critical enablers’ as part of an effective public health response to HIV, or in other words, ‘essential strategies for an enabling environment’ to improve access to harm reduction interventions:



Credit: Juan Fernandez-Ochoa, IDPC

- Supportive legislation, policy and financial commitment, including a call for countries to 'review and revise policies and work towards the decriminalisation of behaviours, such as drug use and possession for personal use' (this will be further discussed [below](#)).
  - Addressing stigma and discrimination, including the adoption and implementation of anti-discrimination laws, the provision of drug user-friendly health and social services, and the training and sensitising of health workers.
  - Community empowerment, including in the planning and delivery of services, especially peer education and training on safer injection, harm reduction and other issues related to the rights and health of people who use drugs.
  - Addressing violence against people who use drugs, including the monitoring and reporting of cases of violence, and mechanisms established to provide justice to cases of violence, the provision of health and other support services to victims of violence, and training of law enforcement and health and social care providers on the rights of people who use drugs.¹⁹⁰
- Nevertheless, the ongoing criminalisation of people who use drugs, law enforcement operations near harm reduction services, the huge stigma and discrimination associated with drug use and the

Figure 3. Availability and coverage of NSPs and OST, by number of countries, 2017¹⁹¹

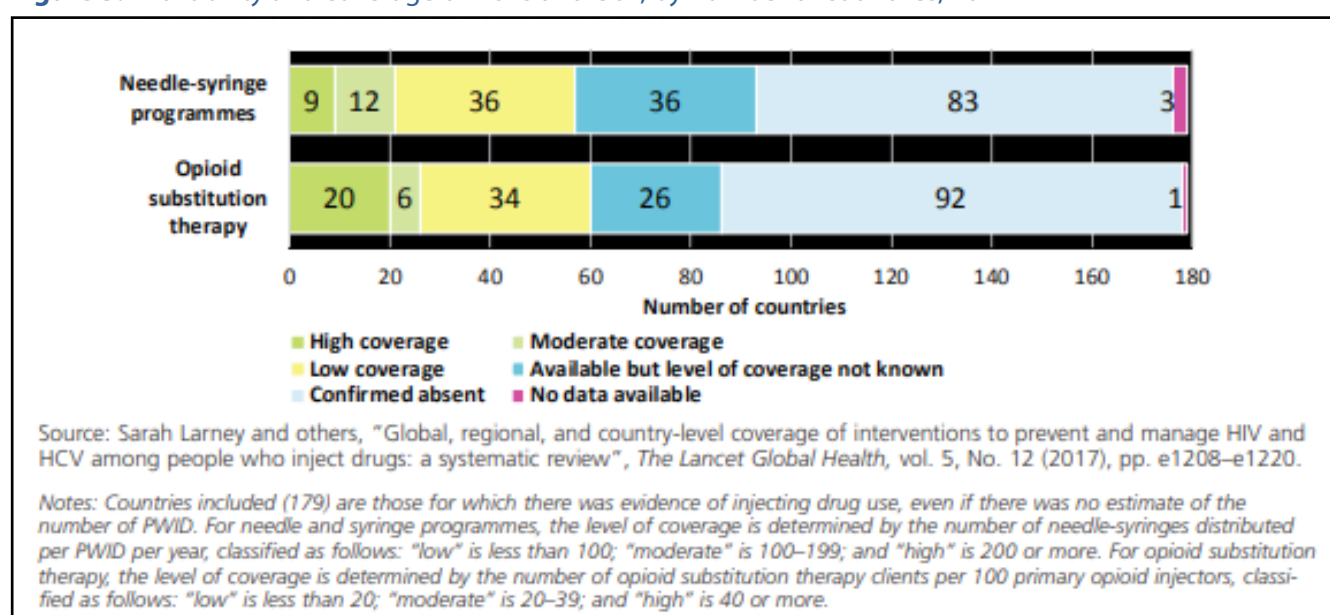
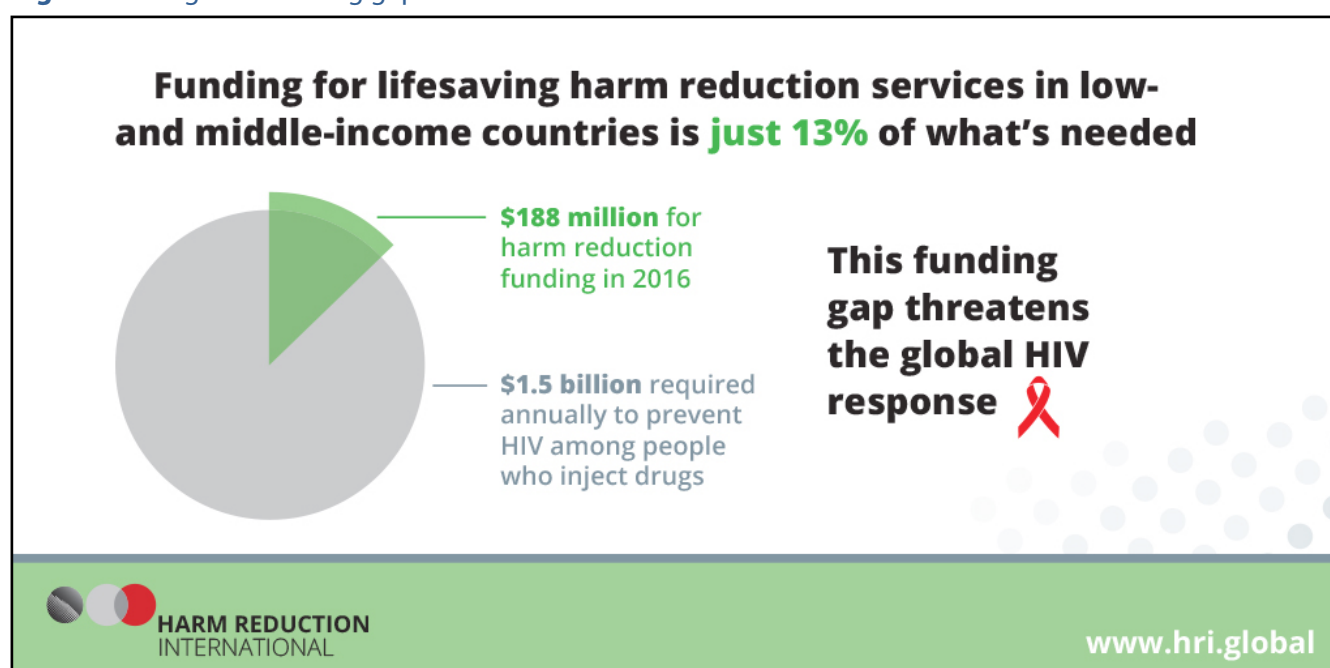
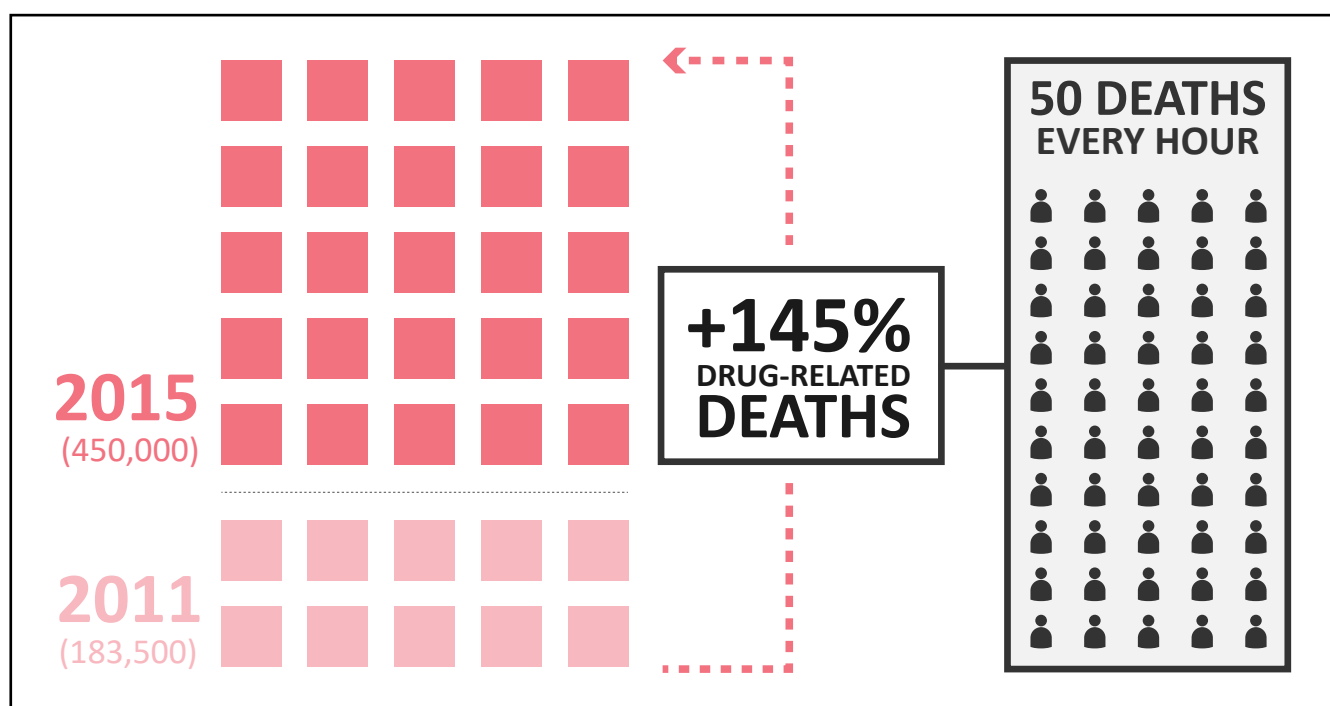


Figure 4. The global funding gap for harm reduction¹⁹²





lack of effective legal protection against these, as well as the widespread cases of violence against people who use drugs in various countries, act as a significant barrier to accessing health and social services.¹⁹³

As a result of these various factors, people who use drugs are made particularly vulnerable to health and social harms. In the 2011 Political Declaration on HIV and AIDS, UN member states had committed to reducing new HIV infections by 50% among people who inject drugs by 2015.¹⁹⁴ As mentioned [above](#), no progress has been made towards this target. On the contrary, both UNAIDS¹⁹⁵ and the UNODC¹⁹⁶ reported that the number of newly infected people who inject drugs had increased by one third between 2011 and 2015, from 114,000 to 152,000 new cases. UNAIDS also estimated that in 2017, the risk for people who inject drugs to acquire HIV was 22 times higher than for the general population.¹⁹⁷ Some regions have been particularly affected, especially Eastern Europe and Central Asia and the Middle East and North Africa, where people who inject drugs accounted for more than one third of new HIV infections in 2017.¹⁹⁸

Similarly, the global prevalence of viral hepatitis C and tuberculosis among people who inject drugs has remained the same or increased slightly between 2009 and 2016 – although these data do not take into account wide differences across countries and regions. The number of drug-related deaths has also increased dramatically during the same period from 183,500 deaths in 2009 to an estimated 450,000 deaths in 2015 – with opioid overdose deaths representing

a third to half of drug-related deaths. Although the USA has been most impacted by the recent surge in overdose deaths (see [Box 4](#)), a similar trend can be observed in Canada (3,987 overdose deaths recorded in 2017)¹⁹⁹ and Europe (9,138 overdose deaths in the EU, Norway and Turkey in 2016).²⁰⁰

Ensuring access to evidence-based drug dependence treatment

2009 Political Declaration and Plan of Action

Action 4(h): ‘Consider developing a comprehensive treatment system offering a wide range of integrated pharmacological (such as detoxification and opioid agonist and antagonist maintenance) and psychosocial (such as counselling, cognitive behavioural therapy and social support) interventions based on scientific evidence and focused on the process of rehabilitation, recovery and social reintegration’

Action 10(b): ‘Ensure, where appropriate, the sufficient availability of substances for medication-assisted therapy, including those within the scope of control under the international drug control conventions, as part of a comprehensive package of services for the treatment of drug dependence’

Action 28(c): ‘Develop prevention and treatment programmes tailored to the specific characteristics of the phenomenon of amphetamine-type stimulants as key elements in any relevant strategy to reduce demand and minimize health risks’

'By denying effective drug treatment, State drug policies intentionally subject a large group of people to severe physical pain, suffering and humiliation, effectively punishing them for using drugs and trying to coerce them into abstinence, in complete disregard of the chronic nature of dependency and of the scientific evidence pointing to the ineffectiveness of punitive measures', Juan E. Mendez, UN Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment, 2013²⁰¹

The UNODC reported little increase in the availability of drug dependence treatment between 2010 and 2016, and coverage remains low. Between 2009 and 2017, only 40% of member states reported high coverage of counselling and treatment planning, while coverage remained low and unchanged for detoxification, OST, peer support groups, screening and brief interventions, contingency management, cognitive behaviour therapy, treatment for comorbidity, motivational interviewing, vocational training, social assistance, education activities, rehabilitation and aftercare.²⁰²

Although OST is the treatment option with the most solid evidence base to manage opioid dependence, it is only operational in less than half of the world, and remains 'the least provided' drug dependence treatment service,²⁰³ despite an increase from 70 to 86 countries providing OST between 2008²⁰⁴ and 2017.²⁰⁵ In various countries, methadone and buprenorphine – the most common drugs used for OST which are also included in the WHO Model List of Essential Medicines²⁰⁶ – are banned in national legislation; this is the case in countries such as Egypt, Jordan, the Russian Federation, Saudi Arabia, Syria, Turkmenistan and Uganda. Countries like the Russian Federation have been criticised by a number of UN human rights treaty bodies for not providing methadone as a form of OST, and several cases on the issue are pending within the European Court of Human Rights.²⁰⁷

When OST is indeed available, additional barriers include cost (with many services only provided in private facilities), accessibility (especially in rural areas and for women and LGBTQ+ individuals), long waiting lists, restrictive prescription and delivery regulations, lack of awareness about OST and available services, and fear of breach of confidentiality.²⁰⁸ Morphine (slow release) and heroin-assisted treatment – another treatment option for opioid dependence with strong evidence of effectiveness²⁰⁹ – remains limited to a small number of countries (Canada, Denmark, Germany, the Netherlands, Spain, Switzerland and the UK), often in the form of pilot or high-threshold programmes with a small number of beneficiaries.²¹⁰

Additionally, substitution treatment for people dependent on stimulants, including ATS and crack/cocaine, is severely limited, and research is lagging behind despite evidence of extensive problematic use and hence clinical need. With regards to ATS dependence, substitution treatment was reported in Australia with dextroamphetamine.²¹¹ In the UK, substitution programmes using dexamphetamine have been in place since 1988, and although no controlled studies were conducted, 'the doctors... generally regard their amphetamine maintenance as clinically successful', with 'significant reductions in amphetamine use, benzodiazepine use, frequency of injection, needle-sharing, and money spent on illicit drugs.'²¹² In Asia, mild plant-based stimulants are used as a form of substitution treatment, including kratom in Thailand and Myanmar,²¹³ and ephedra in China, although more evaluations are needed to assess the effectiveness of these programmes.²¹⁴ Regarding substitution treatment for people dependent on cocaine, several studies have analysed the benefits of using cannabis to help people to regain control over their crack use. In Brazil, available studies have shown that cannabis use helped to reduce craving for crack, improve people's sleep and appetite and improve their overall quality of life.²¹⁵ Similar initiatives have been developed in Jamaica²¹⁶ and Canada.²¹⁷ However, such initiatives remain limited to a few selected countries and localities, and so far scientific evaluations of these interventions have been scarce.

Finally, in many countries, particularly in the global south, the quality of drug dependence treatment provided is questionable and is not based on available scientific evidence,²¹⁸ with cases of ill-treatment and other human rights abuses documented by non-governmental organisations (NGOs) and UN agencies alike.²¹⁹ This is despite the recommendation of Special Rapporteur on the right to health that 'the same standards of ethical treatment apply to the treatment of drug dependence as other health-related conditions', and that 'health-care personnel have an obligation...not to stigmatize or violate a patient's human rights.'²²⁰ The Special Rapporteur on torture has documented several instances of torture and other ill-treatment of people who use drugs in the name of treatment and rehabilitation.²²¹ In 2012, the UNODC published its 'TREATNET Quality standards for drug dependence treatment and care services', in an effort to contribute to 'the development of evidence-based drug dependence treatment services.'²²² However, good quality treatment remains a major issue of concern.

Box 4 The unprecedented opioid overdose crisis in North America

North America has recently experienced an unprecedented number of overdose deaths. In the USA, between 1999 and mid-2018, more than 350,000 people have died from an opioid overdose.²²³ This is six times more than the number of deaths of American soldiers during the entirety of the Vietnam War.²²⁴ The highest number on record was in 2017, when total overdose deaths reached 71,568.²²⁵ The White House estimated the financial cost of the 'opioid epidemic' to be US\$ 504 billion in 2015.²²⁶ People of colour, in particular African American men, have been disproportionately impacted by fatal overdoses.²²⁷ Numerous explanations have been provided for this highly worrying trend. Some have identified the powerful pharmaceutical industry²²⁸ and over-prescription in the 1990s and 2000s while others point to economic insecurity, deindustrialisation,²²⁹ the widespread criminalisation and demonisation of people who use drugs, and their social exclusion.²³⁰

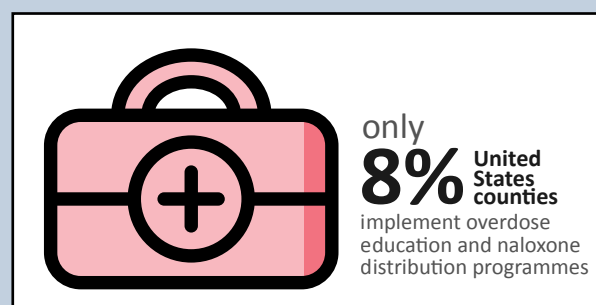
Like the USA, Canada is experiencing an epidemic of opioid-related overdoses. In 2017, a record 3,987 people in Canada died of apparent opioid overdoses, an increase of 34% since 2016.²³¹ The majority of opioid-related deaths involved the potent synthetic opioid fentanyl or fentanyl analogues.²³² In addition to overdose deaths, opioid poisonings in 2016-2017 resulted in an average of 16 hospitalisations a day.²³³

Article 36(b) of the 2009 Political Declaration, and Actions 4(i) and 10(b) commit member states to 'strengthen their efforts aimed at reducing the adverse consequences of drug abuse... such as overdose'. The response to this crisis by the US and Canadian governments has been drastically different in that regard.

In the USA, the Trump White House has acknowledged the severity of the opioid crisis by declaring it as a national emergency,²³⁴ but in the context of rhetoric promoting border crackdowns and other punitive enforcement. When it comes to crucial life-saving healthcare programmes, such as expanded drug dependence treatment, the Trump Administration and the Republican-controlled Congress have moved to curtail funding and cripple the Affordable Care Act. A 2016 report by the Surgeon General found that only 10% of Americans suffering from drug dependence obtain specialty

treatment, due to severe shortages in the supply of care and lack of affordable options.²³⁵ Currently, only 8% of US counties implement overdose education and naloxone distribution programmes – a key harm reduction intervention to reduce the risk of opioid overdose deaths.²³⁶

In the meantime, Canada's federal government chose a 'public health approach to problematic substance use' and adopted a new 'Canadian drugs and substances strategy', under leadership from the Minister of Health.²³⁷ The new strategy restores harm reduction as a key pillar of drug policy (which had been excised entirely in 2007 by the previous government), alongside the other three pillars of treatment, prevention and law enforcement. This was accompanied by legislation to simplify the process of applying for an exemption under federal drug law to operate drug consumption rooms without risk of prosecution to clients or staff for drug possession.²³⁸ As a result, the number of these facilities has grown from one legally-sanctioned room in 2016 to 26 currently operating in four provinces in August 2018, with more applications under review.²³⁹



Credit: Juan Fernandez Ochoa, IDPC

In addition, frustrated by the insufficiently rapid response at various levels of government, community advocates in several cities opened, without legal sanction, lower-barrier pop-up 'overdose prevention sites' to enable easier access to sterile injection equipment and the opportunity for immediate interventions, such as naloxone administration, in the event of an overdose. In response, Health Canada ultimately agreed to give provinces and territories the ability obtain a class exemption from federal drug laws for any provincially-approved overdose prevention sites so as to approve temporary sites based on urgent need, without requiring the lengthy application process for a full service.²⁴⁰ The Federal Parliament also

Continued on next page

passed the Good Samaritan Drug Overdose Act to protect both overdose victims and witnesses from certain charges related to drug possession when seeking emergency help.²⁴¹ Among other additional actions, the federal government has adopted regulatory amendments to make naloxone available without a prescription²⁴² and to remove regulatory barriers to the prescription of methadone and diacetylmorphine (heroin).²⁴³ At international level, Canada, alongside other member states, spearheaded the adoption by the CND of the first-ever resolution addressing stigma

against people who use drugs, including in health and other social services.²⁴⁴ While these efforts are commendable, Canada – as many other countries across the globe – continues to rely on criminal sanctions against all those involved in illegal drug activities, including people who use drugs. The ongoing criminalisation of people who use drugs is an important factor hampering progress in the response to this ‘national public health crisis’.²⁴⁵ It also remains to be seen what impact the recent move towards a legal, regulated cannabis market might have on the opioid crisis.

Ensuring access to drug services for women and girls

2009 Political Declaration and Plan of Action

Action 14(a): ‘Ensure that a broad range of drug demand reduction services, including those in the areas of prevention, treatment, rehabilitation and related support services, provide approaches that serve the needs of vulnerable groups and are differentiated on the basis of scientific evidence so that they respond best to the needs of those groups, taking into account gender considerations and cultural background’

Action 14(c): ‘Provide specialized training for those who work with vulnerable groups, such as patients with psychiatric co-morbidities, minors and women, including pregnant women’

Women and girls are particularly at risk of drug-related health harms because of criminalisation, stigmatisation and social exclusion, which are compounded with endemic gender inequality, gender-based violence and misogyny. In various EU countries, average HIV prevalence can be up to 50% higher among women who use drugs than among their male counterparts.²⁴⁶ Risk factors include the fact that women are more likely than men to be ‘second on the needle’ (i.e. they inject after, and are often injected by, a male partner), the high level of gender stereotyping and stigma associated with their use, which deters them from accessing harm reduction and treatment services, and the severe lack of gender-sensitive drug services. For women sex workers who use drugs, they face additional criminalisation which serves to further enhance their risk of sexual-transmitted or blood-borne infections.²⁴⁷

General Recommendation No. 24 of the UN Committee on the Elimination of Discrimination

Against Women: Article 12 of the Convention (Women and Health) requires that states ‘eliminate discrimination against women in their access to healthcare services throughout the life cycle’.²⁴⁸ Nevertheless, most harm reduction and treatment services continue to be tailored primarily to men who use drugs,²⁴⁹ and many fail to provide suitable environments and support for women and girls, including for example childcare facilities, sexual and reproductive health services, services to tackle gender-based violence, adequate opening hours, geographical access, and staff trained to respond to gender-specific needs.²⁵⁰ Breaches of confidentiality in healthcare settings – a fundamental human rights principle²⁵¹ – in relation to their drug use and HIV status may deter women from accessing services and increases the likelihood of them experiencing exclusion, harassment, abuse and violence. Finally, the fear of loss of child custody when making contact with healthcare providers acts as an important deterrent for mothers to access services.²⁵² In countries or jurisdictions where drug use during pregnancy is criminalised, women may avoid sexual and reproductive health services for fear of arrest, putting themselves and their babies at risk of further harm.²⁵³

As a result, although women make up one third of people who use drugs globally, they only represent one fifth of those in treatment.²⁵⁴ In 2017, the INCB concluded that this was particularly the case ‘in low- and middle-income countries’, mentioning Afghanistan, where ‘women make up only 4% of those in treatment’, and Pakistan, where ‘that figure is 13 per cent’.²⁵⁵ These data suggest that little progress has been made towards Action 14(a) at national level.

The specific challenges faced by women have become more visible in international debates since 2009, although only three CND resolutions have been dedicated to the issue over the past nine years



(that is, only 2% of all resolutions adopted since 2009, see [Box 5](#)). The inclusion, in 2016, of an entire chapter dedicated to the issue of human rights, women, children, youth and vulnerable members of society in the UNGASS Outcome Document is therefore welcome.²⁵⁶ In 2017, the INCB also dedicated the thematic chapter of its Annual Report to women and drugs and a specific section on human rights,²⁵⁷ while Booklet 5 of the 2018 UNODC World Drug Report also focuses exclusively on this issue.²⁵⁸ The UNODC also collaborated with the International Network of People Who Use Drugs, UN Women and the WHO to produce a policy brief analysing the specific needs of women who inject drugs.²⁵⁹ These are late but welcome steps towards providing more visibility to the specific issues faced by women and the need to ensure differentiated responses to guarantee their rights.

Furthermore, Human Rights Council Resolution 37/42 calls upon States to 'mainstream a gender perspective into and ensure the involvement of

women in all stages of the development, implementation, monitoring and evaluation of drug policies and programmes, and to develop and disseminate gender-sensitive and age-appropriate measures that take into account the specific needs and circumstances faced by women and girls with regard to the world drug problem, bearing in mind that targeted interventions that are based on the collection and analysis of data, including age- and gender-related data, can be particularly effective in meeting the specific needs of drug-affected populations and communities.'²⁶⁰

Nevertheless, although issues affecting women are now being discussed in Vienna-based UN agencies, those affecting LGBTQ+ communities have so far been entirely ignored by the CND, although these issues are increasingly being discussed within UNAIDS²⁶¹ and are mentioned in the OHCHR report on UNGASS implementation.²⁶² At local level, various programmes have sought to address the health risks associated with practices like chemsex (i.e. drugs used to accompany, enhance and/or facilitate sexual activity, in particular among gay, bisexual and other men who have sex with men, as well as in queer and fetish communities). These include peer support groups, helplines, distribution of harm reduction paraphernalia and counselling, but overall these initiatives remain severely limited.²⁶³ At national level, Ireland's latest national drug strategy for 2017-2025 explicitly addresses chemsex.²⁶⁴

Ensuring access to prevention services for children and youth

2009 Political Declaration and Plan of Action

Action 14(b) 'Ensure that prevention programmes target and involve youth and children with a view to increasing their reach and effectiveness.'

Box 5 CND resolutions focusing on women

Resolution 61/4. Promoting measures for the prevention of mother-to-child transmission of HIV, hepatitis B and C and syphilis among women who use drugs (2018)

Resolution 59/5. Mainstreaming a gender perspective in drug-related policies and programmes (2016)

Resolution 55/5. Promoting strategies and measures addressing specific needs of women in the context of comprehensive and integrated drug demand reduction programmes and strategies (2012)

The Convention on the Rights of the Child is the only UN human rights treaty making a specific reference to drugs, requiring signatory states to ‘take all appropriate measures...to protect children from the illicit use of narcotic drugs and psychotropic substances’ (Article 33). The Convention also recognises ‘the right of the child to the enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health’ and the obligation for states parties ‘to ensure that no child is deprived of his or her right of access to such health care services’ (Article 24.1).

In an effort to achieve this obligation, most countries have tried to prevent drug use among youth and children with ‘just say no’ messaging and scare tactics, instead of seeking to strengthen protective factors and reduce risk factors leading to drug use, in line with the UNODC International standards on drug use prevention.²⁶⁵ A prominent example of such an approach was promoted by Singapore at the 2016 CND in the form of postcards being shared in schools as a drug prevention strategy.²⁶⁶ Although ‘just say no’ prevention interventions remain widespread, scientific evidence suggests that they have had limited to no impact on drug use prevalence, and have side-lined initiatives with greater efficacy.²⁶⁷

Mandatory drug testing in schools and educational settings have also been used by a number of governments to deter drug use among youth, despite the human rights concerns raised over this practice. Human Rights Watch notably concluded that ‘taking a child’s bodily fluids, whether blood or urine, without their consent may violate the right to bodily integrity and constitute arbitrary interference with their privacy and dignity’. ‘Depending on how such testing occurs’, Human Rights Watch continued, ‘it could also constitute degrading treatment, and may deter children from attending school or college... depriving them of their right to an education.’²⁶⁸ Mandatory drug testing efforts may also be counterproductive, with people switching to less detectable (but sometimes more harmful) substances.

Furthermore, despite efforts to prevent drug use among youth and children, the latest data from the UNODC show that the extent of drug consumption is higher among young people than among older people in most countries, and for most drug types.²⁶⁹ Reflecting this trend, many prevention programmes have not only sought to deter drug use, but have also focused on providing life-saving harm reduction advice and services and aimed to address the wider social issues faced by young people. In its General Comment No. 15, the UN Committee

on Rights of the Child endorsed harm reduction as an important approach to minimising the negative health impacts of drug use among children and young people.²⁷⁰ The Committee also urged states to increase the production and dissemination of accurate and objective information with regards to drug use.²⁷¹ Similarly, the Special Rapporteur on the right to health has stressed the importance of states providing prevention, harm reduction and treatment services specifically tailored to the needs of children and adolescents.²⁷²

In order to better ‘involve youth and children’ in prevention programmes in line with action 14(b), some peer-led drug education initiatives have been developed by civil society. For instance, Students for Sensible Drug Policies, a student-led organisation promoting harm reduction access for young people, recently launched a peer-led programme called ‘Just Say Know.’²⁷³ The programme provides certification and training for young people to become peer educators and organise workshops and seminars on drug education and harm reduction in schools and universities. The programme was piloted in the USA and Nigeria and has received positive feedback from the peer educators, the students and the schools themselves.²⁷⁴ Although this initiative requires further scientific evaluation, it is an interesting example of how to better involve young people in prevention and education campaigns.

To date, limited progress has been made in expanding youth-friendly harm reduction services since 2009, and young people continue to face a number of barriers in accessing harm reduction services, such as age restrictions, the need for parental consent in accessing NSPs and OST, or lack of training on how to respond to their needs.²⁷⁵ To improve young people’s access to youth-friendly harm reduction services, several NGOs have developed toolkits and guides for practitioners.²⁷⁶ Various UN agencies also collaborated with NGOs to produce a technical brief on HIV and young people who inject drugs in 2015.²⁷⁷ These documents recommend expanded access to child and family welfare services, housing, food, social protection benefits, legal assistance, access to education, vocational training and employment, mental health support, as well as harm reduction services in festivals and nightlife settings, including drug checking services.²⁷⁸ The work of youth-led NGOs (e.g. Students for Sensible Drug Policies, Youth Organisation for Drug Action, Youth RISE and others) focusing on harm reduction and drug policy reform has also brought more visibility to the issue and technical expertise on how to address the complex range of problems faced by young people who use drugs.

Ensuring access to drug services in prisons

2009 Political Declaration and Plan of Action

Action 15(a): 'Working within their legal frameworks and in compliance with applicable international law, consider allowing the full implementation of drug dependence treatment and care options for offenders, in particular, when appropriate, providing treatment as an alternative to incarceration'

Action 15(c): 'Implement comprehensive treatment programmes in detention facilities; commit themselves to offering a range of treatment, care and related support services to drug-dependent inmates, including those aimed at prevention of the transmission of related infectious diseases, pharmacological and psychosocial treatment and rehabilitation; and further commit themselves to providing programmes aimed at preparation for release and prisoner support programmes for the transition between incarceration and release, re-entry and social reintegration'

Action 16(d): 'Provide appropriate training so that criminal justice and/or prison staff carry out drug demand reduction measures that are based on scientific evidence and are ethical and so that their attitudes are respectful, non-judgemental and non-stigmatizing'

According to the Nelson Mandela Rules, the right to the highest attainable standard of physical and mental health extends to people held in prison and other closed settings. As such, people in custody should receive a level of healthcare comparable to that available to people in the community and without discrimination.²⁷⁹

There are an estimated 10 million people incarcerated worldwide,²⁸⁰ and evidence shows that prisons are high risk environments for the spread of communicable diseases, with 'the prevalence of HIV, HBV and tuberculosis among people in prison and other closed settings...2 to 10 times higher than among the general population'.²⁸¹ In some regions, the Americas in particular, incarceration is driven by the mass incarceration of low-level drug offenders. It is therefore unsurprising that drug use in closed settings remains high. Worldwide, the UNODC estimates that around one in three prisoners have used drugs at least once while in prisons,²⁸² stating that 'prisoners are at higher risk for infectious diseases

Box 6 UN comprehensive package of 15 key interventions in prison

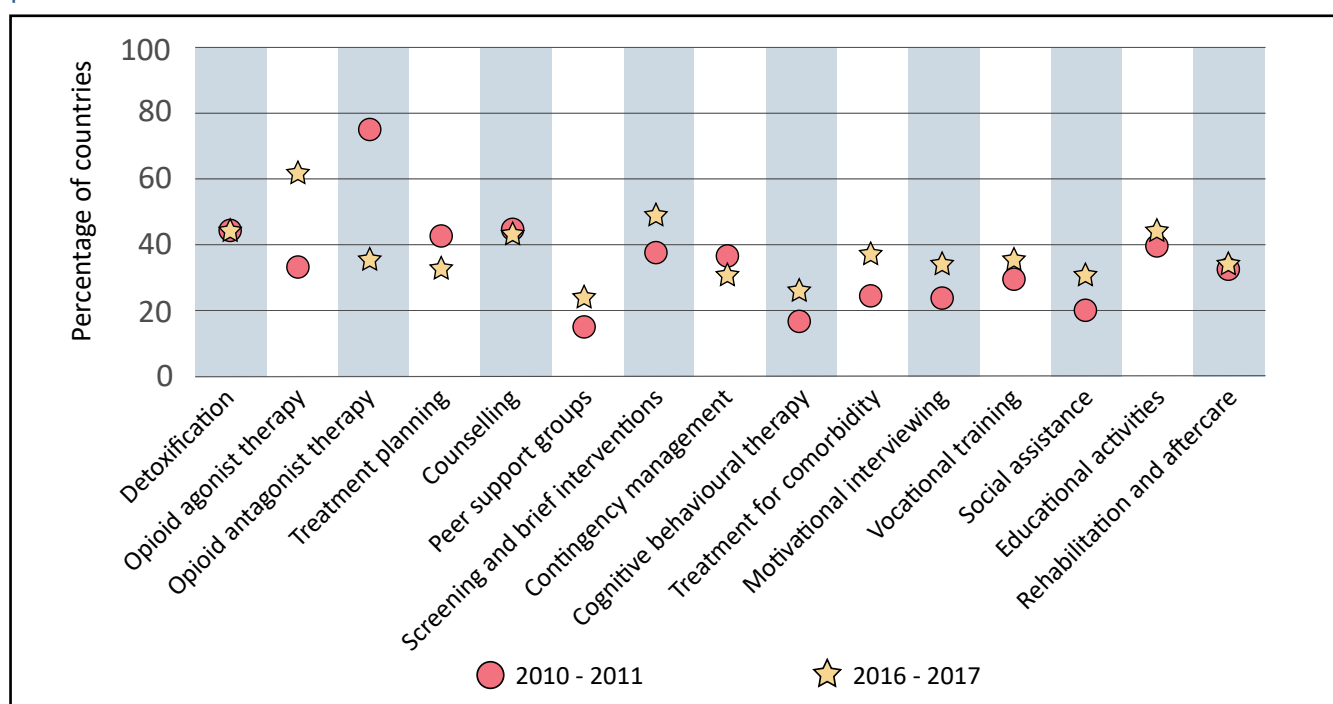
In 2013, the UNODC, the International Labour Organization, UNDP, the WHO and UNAIDS released a policy brief on the prevention, treatment and care of HIV in prisons and other closed settings which promotes a comprehensive package of 15 interventions:

1. Information, education and communication
2. Condom programmes
3. Prevention of sexual violence
4. Drug dependence treatment, including opioid substitution therapy
5. Needle and syringe programmes
6. Prevention of transmission through medical or dental services
7. Prevention of transmission through tattooing, piercing and other forms of skin penetration
8. Post-exposure prophylaxis
9. HIV testing and counselling
10. HIV treatment, care and support
11. Prevention, diagnosis and treatment of tuberculosis
12. Prevention of mother-to-child transmission
13. Prevention and treatment of sexually transmitted infections
14. Vaccination, diagnosis and treatment of viral hepatitis
15. Protecting staff from occupational hazards.²⁸³

but are poorly served'.²⁸⁴ UNAIDS also estimated that rates of drug injection among prisoners ranged from 2 to 38% in Europe, 34% in Canada and up to 55% in Australia.²⁸⁵ Where there is little or no access to sterile injection equipment in such settings, it follows that most injection involves the sharing, often by multiple people, of non-sterile equipment, often makeshift 'rigs' fashioned from other items.

The UNODC found that the level of access to a comprehensive range of drug dependence treatment in prisons has only marginally improved between 2010 and 2017, while coverage of some services had

Figure 5. Comparing the percentage of countries reporting a high degree of coverage of treatment services in prisons between 2010 and 2017²⁸⁶



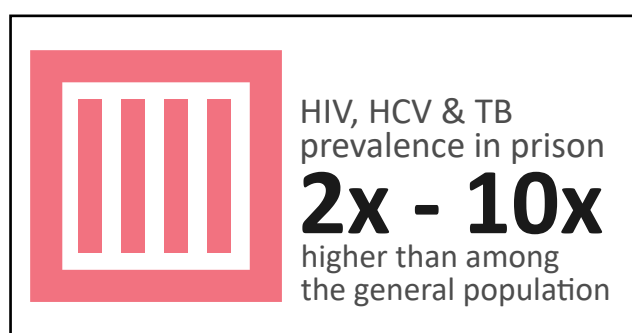
Credit: Juan Fernandez Ochoa, IDPC, based on original figure from the UNODC

actually decreased during the 2010-2017 period, including for opioid antagonist therapy, treatment planning and contingency management (see Figure 5).²⁸⁷ However, access to OST in prison has improved, being available in 52 countries in 2016²⁸⁸ compared to 33 in 2008.²⁸⁹

Despite such progress, however, more than 140 countries still have no access to OST in prison settings, in contravention of the right to health of people deprived of their liberty. In countries where it is available, OST is sometimes only available in one or two prisons, generally in male prisons – even though women incarcerated for drug offences ‘suffer worse consequences than men’, meaning that women generally have no access to these programmes while incarcerated.²⁹⁰ This is despite the recommendation from the UN Committee on the Elimination of Discrimination against Women that ‘gender-sensitive and evidence-based drug treatment services to reduce harmful effects for women who use drugs, including harm reduction programmes for women in detention’ should be available.²⁹¹ In some cases, people can only access OST in prison if they were

already receiving OST prior to their incarceration. Treatment quality also remains an issue, with services available ‘not necessarily of the same standard as those provided in the community’.²⁹² Additional issues include long waiting times to access treatment, unnecessary restrictions for some prisoners, and the ongoing stigma and discrimination associated with OST in prison.²⁹³

With regards to other drug services in prison, in particular those included in the UN comprehensive package of 15 key interventions in prison (see Box 6), the UNODC reported that only antiretroviral therapy and HIV testing and counselling were consistently reported to be widely available in prison settings, and coverage for tuberculosis prevention, diagnosis and treatment among people who use drugs has increased since 2014.²⁹⁴ However, the availability of NSPs in prison, which was already limited to only 10 countries in 2010,²⁹⁵ was further reduced in 2016 to only eight countries, with Iran and Romania having closed down their services.²⁹⁶ Discussions are underway in Canada to start implementing NSPs in all federal prisons. Condoms are rarely made available in prisons despite the higher risks of contracting sexually transmitted diseases while in prison.²⁹⁷ Little progress was also made in expanding the provision of measures aimed at reducing the risks of overdose, despite the fact that ‘people who use heroin are exposed to a severe risk of death from overdose after release from prison, especially in the first two weeks’.²⁹⁸ In 2016, only a small number of countries provided varying degrees of overdose prevention training and distributed naloxone to prisoners on or prior to their release,



Credit: Juan Fernandez Ochoa, IDPC

including Estonia, Ireland, Norway, Spain, the UK,²⁹⁹ various provinces in Canada and two US states.³⁰⁰

In terms of progress towards Action 16(d), trainings targeted at criminal justice and prison staff on demand reduction measures in prison settings have fallen in 2016-2017 to the 'lowest recorded level', with a decrease most noticeable among 'law enforcement and prison staff'.³⁰¹ The UNODC also reported that 'harm reduction activities initiated by officers were primarily focused on the potential threat of prisoner-to-staff transmission',³⁰² rather than aiming to reduce the health risks of drug use among prison inmates.

Providing alternatives to prison or punishment for people who use drugs

2009 Political Declaration and Plan of Action

Action 15(a): 'Working within their legal frameworks and in compliance with applicable international law, consider allowing the full implementation of drug dependence treatment and care options for offenders, in particular, when appropriate, providing treatment as an alternative to incarceration'

'A criminal record for a young person for a minor drug offence can be a far greater threat to their well-being than occasional drug use', Kofi Annan, former UN Secretary General³⁰³

Article 4(c) of the 1988 UN Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances provides that 'in appropriate cases of a minor nature, the Parties may provide, *as alternatives to conviction or punishment*, measures such as education, rehabilitation or social reintegration, as well as, when the offender is a drug abuser, treatment and aftercare' (emphasis added).³⁰⁴ The 2009 Plan of Action also promotes for the use of such alternatives in action 15(a), while recognising 'the concept of drug dependence as a multifactorial health and social problem' in action 2(g). Despite these commitments, data from the UN Commission on Crime Prevention and Criminal Justice (CCPCJ) shows that one in five prisoners worldwide is incarcerated for a drug offence,³⁰⁵ of whom 83% are in prison for drug use or possession for personal use.³⁰⁶

The need to make better use of alternatives to prison and punishment for people who use drugs has been recognised in paragraph 4.j of the UNGASS Outcome Document,³⁰⁷ in CND resolution 58/5 'Supporting the collaboration of public health and justice authorities in pursuing alternative measures to conviction or

26 countries
have adopted a model of
decriminalisation



Credit: Juan Fernandez Ochoa, IDPC

punishment for appropriate drug related offences of a minor nature,³⁰⁸ and by a number of UN agencies and entities that have called for the decriminalisation of people who use drugs, including the UNODC,³⁰⁹ the OHCHR,³¹⁰ UNAIDS,³¹¹ WHO,³¹² the United Nations Development Programme,³¹³ a number of UN Special Rapporteurs on human rights,³¹⁴ the UN Committee on Economic Social and Cultural Rights,³¹⁵ UN Women,³¹⁶ as well as the UN High Commissioner for Refugees, UNICEF, the World Food Programme, the International Labour Organization, UNESCO, the UN Population Fund and the International Organization for Migration.³¹⁷ Similarly, various regional bodies have given visibility to the issue. In 2015, CICAD commissioned a study on the availability and effectiveness of alternatives to incarceration to inform the debate in the Americas,³¹⁸ and also concluded that 'Decriminalization of drug use needs to be considered as a core element in any public health strategy'.³¹⁹ More recently, the Inter-American Commission on Human Rights recommended the decriminalisation of drug use and possession for personal use as a way of reducing pre-trial detention and improving prison conditions.³²⁰ The European Union also released a study on the various alternatives to incarceration across the region³²¹ and adopted Council Conclusions in support of the practice.³²² Finally, the need for 'alternatives to incarceration for minor offenses' featured in the African Union's 2013-2017 Plan of Action on Drug Control.³²³

At national level, only 26 countries have adopted a decriminalisation model, whether *de jure* (enshrined in the law), or *de facto* (in practice only), focusing on all substances for some or only cannabis for many others.³²⁴ These include: Armenia, various provinces in Australia, Belgium, Chile, Colombia, Costa Rica, Croatia, the Czech Republic, Ecuador, Estonia, Germany, Israel, Italy, Jamaica, Latvia, Mexico, the Netherlands, Paraguay, Peru, Poland, Portugal, Slovenia, Spain, Switzerland, various US states and Uruguay.³²⁵ In Argentina and Georgia, the criminalisation of drug possession for personal use was ruled as unconstitutional, but no legislative reform has yet taken place in either country. Only six of the countries

Box 7 A health and social response to drug use: The case of Portugal

The Portuguese decriminalisation policy emerged in 2000 – under the leadership of former President and current UN Secretary General Antonio Guterres – thanks to a confluence of several political and social factors. At the time, the HIV epidemic among people who use drugs had surged massively, more than 75% of prisoners were incarcerated for drug-related crimes, and mass media was fuelling public fears that people using drugs would inevitably die. As a result, drug policy quickly became the top priority of the government. A commission, composed of experts from different backgrounds and expertise, was established in 1998 to draft a new ‘National strategy to fight against drugs’. At the time, the country’s strategy already promoted inclusiveness and broad participation of people who use drugs, their families, health and education professionals, the courts, the community, etc. The national strategy was approved in April 1999, enshrining in the law the fundamental principles of humanism, pragmatism, innovation, the importance of scientific evidence, as well as community participation in drug policy design and implementation.

The decriminalisation model was officially adopted with Law 30/2000 in July 2001, and was followed by significant investments in a broad and coordinated network of health and social services. Law 30/2000 introduced a system of referral to administrative panels called ‘Commissions for the Dissuasion of Drug Addiction’. A person detained by the police with up to 10 days’ worth of drugs is referred to the Commission which can orientate them towards voluntary harm reduction and treatment services, social services, and also impose fines and community service – although sanctions are rarely used in practice.

Although still enshrined in a punitive approach, the model adopted in Portugal has nonetheless greatly improved health outcomes, with a drop in new HIV infections attributed to injection, reduced numbers of overdose deaths, and a significantly lower rate of drug-induced mortality among adults than the European average (3.86 deaths per million recorded in Portugal compared to 21.8 deaths per million

across the EU in 2016). The policy has also facilitated access to voluntary drug dependence treatment and harm reduction interventions, and has reduced the incarceration rate for drug offences, while enabling law enforcement efforts to focus on high-level traffickers and organised crime.³²⁶

However, even the Portuguese decriminalisation model is facing various challenges, not least the issue of funding. Harm reduction services in Portugal are mainly provided by NGOs, with a strong community basis, and are funded by up to 80% by the state, with NGOs covering the remaining 20%. Government budget cuts, combined with the difficulty for NGOs to raise money for an issue that is no longer a top priority for Portuguese society, have resulted in hard working conditions, low salaries and lack of training for harm reduction service providers. The Portuguese Harm Reduction Network submitted a set of recommendations to the Health Secretary of State in October 2017 to improve harm reduction sustainability, including the need to change the funding rules for drug services. So far, however, no change has been made, and the Portuguese policy remains under pressure. Recent reforms have also split the management of drug services into two branches, the first managed by the Portuguese drug agency (Serviço de Intervenção nos Comportamentos Aditivos e nas Dependências) and in charge of defining the national strategy, producing information, introducing innovation and evaluating implementation; and the second concerned with local diagnosis of needs and implementation.³²⁷ Tension and lack of coordination between the two branches are also issues of concern. Finally, although drug use is decriminalised, people continue to rely on the criminal black market to purchase their drug of choice, with no control over the purity or quality of the substance used. Nevertheless, and despite these challenges, the Portuguese decriminalisation policy is regarded as an important model, having proven its effectiveness in protecting the health and improving the social inclusion of people who use drugs.



listed above – Croatia, the Czech Republic, Ecuador, Israel, Jamaica and Mexico; the province of Western Australia and several US states made their move towards decriminalisation during the period 2009–2018, with ongoing discussions in several countries such as Ghana, Ireland, Norway and Tunisia. Canada is expected to bring into force, in late 2018, legislation decriminalising possession of cannabis for personal use, although the government continues to reject calls to decriminalise possession of other substances. The low prevalence of decriminalisation among member states as a viable alternative to punitive approaches persists, despite increasing evidence that removing criminal sanctions against people who use drugs can reduce prison overcrowding, improve health outcomes, and address drug use-related stigma and discrimination.³²⁸ The decriminalisation models adopted in the countries mentioned above vary considerably, as do their level of effectiveness.³²⁹ The model with the most solid evidence base is Portugal³³⁰ (see [Box 7](#)).

Some countries do not impose criminal sanctions against drug use or possession for personal use *per se* but continue to use excessive and disproportionate administrative punishments that violate a number of human rights, including the rights to health, liberty and privacy. These include compulsory detention (see [below](#)), forced urine testing (including in Azerbaijan, Bangladesh, Cambodia, China, Georgia, Indonesia, Iran, Kazakhstan, Kyrgyzstan, Lao PDR, Malaysia, Myanmar, Pakistan, the Philippines, Singapore, South Korea, Sri Lanka, Tajikistan, Thailand, Turkey, Turkmenistan,

Vietnam and Uzbekistan) and compulsory registration requirements for people who use drugs (used in Azerbaijan, Brunei Darussalam, Cambodia, China, India, Indonesia, Japan, Kazakhstan, Kyrgyzstan, Lao PDR, Malaysia, Myanmar, Pakistan, Tajikistan, Turkmenistan and Uzbekistan).³³¹ In some countries, including Vietnam, the Philippines and Indonesia, the families of people who use drugs and/or the general public are required, or strongly encouraged, to report people who use drugs to public authorities. In some cases, law enforcement agencies use these registries and the information they contain for interrogation purposes.³³² In 2013, the UN Special Rapporteur on Torture concluded that ‘Use of drug registries – where people who use drugs are identified and listed by police and health-care workers, and their civil rights curtailed – are violations of patient confidentiality that lead to further ill-treatment by health providers.’³³³ These practices also act as a strong deterrent for accessing life-saving health and social services.³³⁴

Other countries or jurisdictions which have not decriminalised drug use have nonetheless adopted diversion models for people who use drugs, which can be triggered at time of arrest, during trial and post-incarceration. The level of effectiveness for these alternatives to incarceration varies greatly.³³⁵ For instance, the drug courts model implemented in the USA and promoted in various regions of the world, especially in Latin America, has been subject to considerable criticism. A 2018 comprehensive study of drug courts implemented across the Americas has found that they were ‘a costly, cumbersome intervention that has limited, if any,

Box 8 Addressing the health impacts of aerial spraying of crops cultivated for drug production

The 2009 Political Declaration and its Plan of Action focus exclusively on the health aspects of drug use, without considering the health implications of supply reduction efforts in areas affected by illegal crop cultivation. This is despite evidence that forced crop eradication through aerial spraying using harmful herbicides have had severe impacts on the rights and health of local communities. In 2015, the WHO International Agency for Research on Cancer concluded that glyphosate – often used for aerial spraying – ‘probably causes cancer’,³³⁶ while the UN Special Rapporteur on the Right to Health declared that there was ‘trustworthy evidence that aerial fumigation with glyphosate...damages the physical health’³³⁷ of affected communities. This includes respiratory problems, skin rashes, diarrhoea, eye problems and miscarriages.³³⁸

Aerial spraying also has indirect health impacts. In Colombia, for instance, aerial spraying has damaged legal subsistence food crops such as bananas, beans, plantains and yuca, as well as chicken and fish farms, located near coca fields.³³⁹ In such contexts, subsistence farmers not only lose their main source of income (coca and other crops destined for the illegal drug market), but also their main source of food (as is the case with any form of forced eradication). Furthermore, aerial spraying can damage rivers and waters, threatening to leave entire communities without access to clean water.³⁴⁰

impact on reducing incarceration. Indeed, for many it may have the opposite effect: increasing criminal justice supervision and subjecting participants who fail to graduate to harsher penalties than they may have otherwise received.³⁴¹ In many cases, instead of focusing on people dependent on drugs having committed other offences, drug courts focus on people caught for simple drug use or possession for personal use (generally cannabis). The unavailability of evidence-based treatment programmes in various countries in the region also acts as a significant

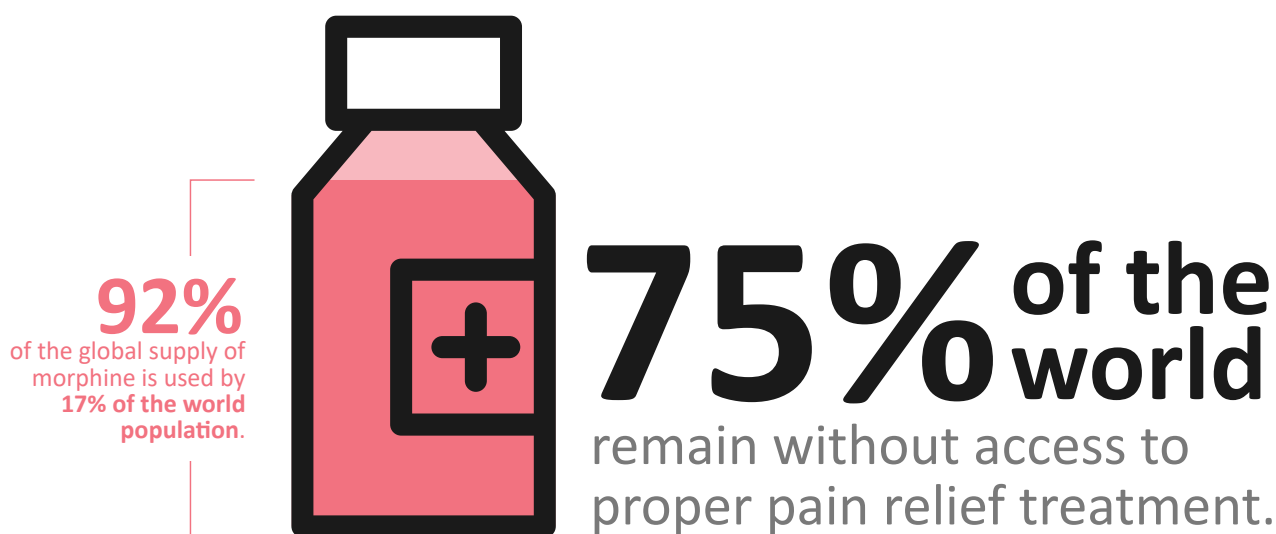
barrier to an effective drug court system.³⁴² Other approaches have yielded better results. For example, the Law Enforcement Assisted Diversion (LEAD) programme launched in 2011 in Seattle, USA, has focused on diverting people who use drugs at the time of arrest to a case worker providing health and social guidance on a case-by-case basis. Evaluations of the programme have shown positive results, and similar initiatives are now being implemented in other US cities.³⁴³

Improving access to controlled substances for medical purposes

2009 Political Declaration and Plan of Action

Action 10(c): ‘Continue to comply with the procedures established under the international drug control conventions and relevant resolutions of the Economic and Social Council relating to the submission to the International Narcotics Control Board of estimates of their requirements for narcotic drugs and assessments of requirements for psychotropic substances so as to facilitate the import of the required narcotic drugs and psychotropic substances and to enable the Board, in cooperation with Governments, to maintain a balance between the demand for and the supply of those drugs and substances in order to ensure the relief of pain and suffering and the availability of medication-assisted therapy as part of a comprehensive package of services for the treatment of drug dependence, while bearing in mind, in accordance with national legislation, the World Health Organization Model List of Essential Medicines’

One of the stated key objectives of the UN drug control treaties is to ensure access to controlled substances for medical and scientific purposes – but only one action in the entire 2009 Political Declaration and Plan of Action is dedicated to the issue: Action 10(c). The cornerstone essential medicine for palliative care and pain relief is oral morphine. In its General Comment No. 14, the UN Committee on Economic, Social and Cultural Rights also recognised the obligations for member states to ‘respect the right to health by, inter alia, refraining from denying or limiting equal access for all persons...to preventive, curative and palliative health services’, and ensure the availability of ‘essential drugs’ included on the WHO Model List of Essential Medicines without delay as a ‘core minimum obligation’.³⁴⁴



In 2010, the INCB reported that 'Although medical science has the capacity to provide relief for most forms of moderate to severe pain, over 80 per cent of the world population will have insufficient analgesia, or no analgesia at all, if they suffer from such pain'.³⁴⁵ In 2015, the INCB published a special report on access to controlled medicines, which showed little improvement from the 2009 data. In its special report, the INCB concluded that 'Around 5.5 billion people still have limited or no access to medicines containing narcotic drugs, such as codeine or morphine, leaving 75 per cent of the world population without access to proper pain relief treatment. Around 92 per cent of morphine used worldwide is consumed in countries in which only 17 per cent of the world population lives: primarily the United States of America, Canada, Western Europe, Australia and New Zealand'.³⁴⁶ In 2017, a study also estimated that 298.5 metric tonnes of morphine-equivalent opioids were distributed in the world each year, but only 0.1 metric tonnes (0.03%) were made available in low-income countries. As a result, 25.5 million people who died in 2015 – representing 45% of all global deaths that year – experienced serious health-related suffering. 80% of these deaths were in developing regions of the world. The study also found that each year, 2.5 million children die experiencing serious health-related suffering. 98% of these children lived in developing countries, and 93% of these deaths were avoidable.³⁴⁷

The need to ensure access to 'essential medicines, including controlled medicines' for surgical care and anaesthesia was also recognised by the World Health Assembly as an essential component of universal health coverage. The World Health Assembly also noted that a large proportion of the global population had limited access to opioid analgesics for pain relief, and that 5.5 billion people (i.e. 83% of the world's population) lived in countries with low to non-existent access to analgesics, with only 710 million people (11% of the world's population) having moderate to adequate access.³⁴⁸

In 2013, the Special Rapporteur on torture concluded that 'Ensuring the availability and accessibility of medications included in the WHO Model List of Essential Medicines' was 'a legal obligation under the Single Convention on Narcotic Drugs, 1961', adding that 'When the failure of States to take positive steps, or to refrain from interfering with health-care services, condemns patients to unnecessary suffering from pain, States not only fall foul of the right to health but may also violate an affirmative obligation under the prohibition of torture and ill-treatment'.³⁴⁹

The severe lack of access to controlled substances for medical purposes is driven, among other issues, by national rules and regulations around controlled medicines that go far beyond the requirements of the 1961 and 1971 drug control treaties. These

include overly strict requirements such as special prescription forms, limitations on the number of days a prescription can cover, limitations on which healthcare workers can prescribe controlled substances, the criminalisation of healthcare providers for prescribing medications and the resulting fear of arrest, requirements for additional licenses for hospitals, pharmacists and healthcare workers, additional record keeping or reporting requirements, and limitations on the daily doses that can be prescribed. Lack of understanding and training about palliative care and pain relief – in particular ‘opiophobia’ – are also important barriers to improving the availability of controlled medicines.³⁵⁰ The funding gap is also a major issue for ensuring adequate access to controlled medicines – although it is estimated that ‘the cost of meeting the global shortfall of about 48.5 metric tonnes of morphine-equivalent opioids is about \$145 million per year’, the equivalent of 0.0002% of global GDP.³⁵¹

Despite the urgency of ensuring better access to controlled medicines, only four CND resolutions were adopted on this issue since 2009 (see [Box 9](#)) – representing just 3% of all CND resolutions adopted between 2009 and 2018. The UNGASS Outcome Document has made considerable progress in this area, with an entire chapter aimed at improving access to controlled substances for medical and scientific purposes.³⁵² In 2014, the World Health Assembly also adopted Resolution 67.19 ‘Strengthening of palliative care as a component of comprehensive care throughout the life course’, noting CND resolutions 53/4 and 54/6, and recognising that ‘access to palliative care and to essential medicines...including opioid analgesics such as morphine, in line with the three United Nations international drug control conventions, contributes to the realization of the right to the enjoyment of the highest attainable standard of health and well-being.’³⁵³ In 2018, in order to provide ‘concrete information about actions Member States can take to address the negative health outcomes, such as the enormous burden of untreated pain around the world, associated with inadequate access to controlled medicines’, the UNODC released its ‘Technical guidance: Increasing access and availability of controlled medicines.’³⁵⁴

Some progress has been made in various countries to improve access to and availability of controlled medicines, including in Costa Rica, India, Mexico, Uganda (see [Box 10](#)) and Ukraine – with Kenya, Malawi, Nigeria, Rwanda and Swaziland expected to follow similar steps undertaken by Uganda.³⁵⁵ These have included the removal of regulatory barriers

Box 9 CND resolutions adopted on access to controlled medicines since 2009

Resolution 57/10. Preventing the diversion of ketamine from legal sources while ensuring its availability for medical use (2014)

Resolution 54/6. Promoting adequate availability of internationally controlled narcotic drugs and psychotropic substances for medical and scientific purposes while preventing their diversion and abuse (2011)

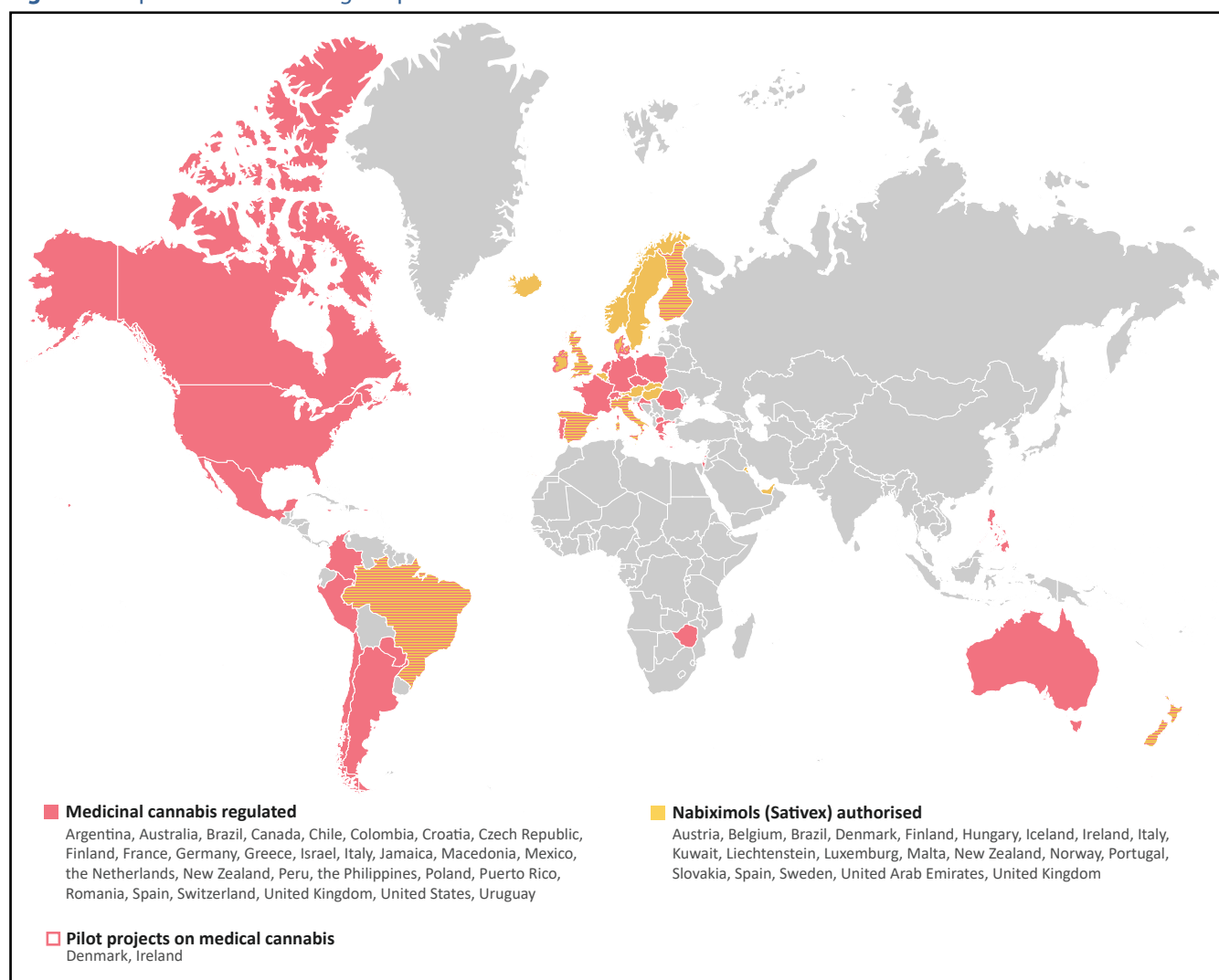
Resolution 54/3. Ensuring the availability of reference and test samples of controlled substances at drug testing laboratories for scientific purposes (2011)

Resolution 53/4. Promoting adequate availability of internationally controlled licit drugs for medical and scientific purposes while preventing their diversion and abuse (2010)

hampering access, increased empowerment and training of frontline healthcare workers, the adoption of a palliative care policy or strategy, and the allocation of more funding towards providing access to palliative care and pain relief.³⁵⁶

It is in the field of medicinal cannabis that most progress has been made since the adoption of the 2009 Political Declaration – despite the UN drug control system delineating cannabis as a drug whose liability ‘to abuse and to produce ill effects...is not offset by substantial therapeutic advantages.’³⁵⁷ 48 countries now provide some form of medicinal cannabis for a number of ailments (see [Figure 6](#)).³⁵⁸ 24 of these countries have adopted or reviewed drug legislations to allow or expand access to medicinal cannabis between 2009 and 2018, including Argentina, Australia, Brazil, Chile, Colombia, Croatia, the Czech Republic, France, Germany, Greece, Italy, Jamaica, Lesotho, Luxembourg, Malta, Macedonia, Mexico, Peru, the Philippines, Poland, Portugal, Romania, various states in the USA and Zimbabwe. In the UK, a recent scandal involving a 12-year old boy whose anti-epileptic medicine (cannabidiol oil) was confiscated by customs agents at a London airport showcased the urgent need to review drug legislations and ensure broader access to

Figure 6. Map of countries having adopted medicinal cannabis schemes³⁵⁹



Credit: Updated from IDPC/MUCD briefing paper on medicinal cannabis

medicinal cannabis for children with epilepsy.³⁶⁰ As a result of intense civil society pressure, the UK Home Office announced that it would make certain products available on prescription imminently based on advice from medical authorities – and would reschedule cannabis to Schedule 2 of the Misuse of Drugs Regulations 2001.³⁶¹

In response to the rapid expansion of medicinal cannabis worldwide, the INCB released guidelines for member states to follow to ensure compliance with the UN drug control treaties.³⁶² In addition, for the first time in 83 years, a scientific assessment by the WHO Expert Committee on Drug Dependence (ECDD) on cannabis and its derivatives is underway. In its provisional conclusions, the ECDD recommended that pure CBD ‘should not be scheduled within the International Drug Control Conventions’. The ECDD also decided to proceed to a critical review of cannabis plant and resin, extracts and tinctures of cannabis, Delta-9-THC and isomers of THC, with conclusions planned to be released on time for the 2019 Ministerial Segment.³⁶³

2.1.2 The right to enjoy the benefits of scientific research

2009 Political Declaration and Plan of Action

Action 22(I): ‘Remain up to date on scientific studies, data and research on the medicinal and other legitimate uses of plants containing narcotic and psychotropic substances, taking into account the provisions of the three international drug control conventions’

Article 15 of the International Covenant on Economic, Social and Cultural Rights³⁶⁴ recognises ‘the right of everyone...to enjoy the benefits of scientific progress and its applications’, and ‘the freedom indispensable for scientific research and creative activity’.³⁶⁵ The UN drug conventions also promote access to controlled substances for research purposes, with a view to assessing their potential medicinal use. This is recognised and encouraged in Action 22(I) of the 2009 Political Declaration and Plan of Action.

Box 10 Improving access to controlled medicines in Uganda

Uganda has become a leader in East Africa for improving access to palliative care. Although coverage remains severely limited with 90% of Ugandans in need not being able to access palliative care,³⁶⁶ over the past 20 years the government has undertaken a number of steps to improve the situation.

These steps have included incorporating palliative care in the Ugandan 'Health sector development plan for 2015/16 to 2019/20',³⁶⁷ and the approval of the first 'National palliative care policy' in 2015,³⁶⁸ hence providing a comprehensive framework to scale up palliative care services nationwide. Palliative care was also integrated in the curriculum of healthcare professionals, in an effort to facilitate its application in mainstream healthcare, but also to broaden the range of opioid prescribers – allowing nurses and clinical officers to prescribe oral morphine for pain management.³⁶⁹ The registration of oral morphine as a palliative care treatment by the National Drug Authority and its inclusion into Uganda's national list of essential medicines was also instrumental to ensure better access to the medicine for pain relief and palliative care. Other factors of success have included a long-standing relationship between the Ministry of Health, Hospice Africa Uganda, the Palliative Care Association of Uganda and the private sector,³⁷⁰ as well as

the allocation of government funding to purchase morphine. Finally, efforts were made to destigmatise and conduct more research on palliative care.

Despite these positive steps, various obstacles remain. For instance, the Narcotic Drugs and Psychotropic Substances (Control) Act, promulgated in 2015, inadvertently made prescription and dispensation of morphine by nurses illegal, hampering efforts to expand palliative care since nurses are at the frontlines of palliative care provision. The 2015 legislation, drafted by the Ministry of Internal Affairs without consultation with the Ministry of Health, also approved an approach overly focused on interdiction of drug use and trafficking, greatly impacting upon access to controlled substances for palliative care and pain relief and hindering the realisation of the right to health.³⁷¹ Civil society calls to reform the 2015 Act led to the creation of an ad hoc committee in September 2017. Comprised of representatives from the Ministry of Health, the Ministry of Internal Affairs and civil society, the committee advises the government on issues related to palliative care and harm reduction, and on how to improve the 2015 legislation. In the meantime, the Chief of Counter-Narcotics has committed not to prosecute nurses prescribing and dispensing morphine.

However, there remains significant barriers in medical research on controlled drugs, with little improvement since 2009. The classification of substances like LSD, MDMA, cathinone and psilocybin in Schedule I of the 1971 Convention and of cannabis in Schedules I and IV of the 1961 Convention has resulted in tight controls at national level, severely restricting their access for scientific research due to the bureaucracy associated with conducting research or clinical trials.³⁷² In the UK, for example, obtaining a Schedule 1 licence under the Misuse of Drugs Act to conduct scientific research takes over a year, costs around GBP 5,000 (US\$ 6,500), and requires high levels of security for the research facility.³⁷³ Obtaining the substance itself may also present difficulties as they are usually unavailable from standard chemical manufacturers. Furthermore, the fact that these substances are placed in Schedule I – and are therefore considered as dangerous with little therapeutic value – was found to be 'a powerful deterrent to

grant-giving bodies', further hampering research.³⁷⁴ Finally, the fear and threat of prosecution of doctors and scientists involved in such research may also act as yet another barrier.³⁷⁵

This is despite growing evidence of the potential benefits of these substances to treat a number of illnesses. Available scientific evidence, for instance, supports the potential therapeutic use of cannabis in neurological diseases³⁷⁶ such as multiple sclerosis³⁷⁷ and epilepsy,³⁷⁸ chronic pain³⁷⁹ and appetite stimulation.³⁸⁰ Similarly, several studies have highlighted the possible benefits of MDMA for patients with treatment-resistant post-traumatic stress disorder, of LSD for cluster headaches, and of psilocybin for obsessive-compulsive disorder and cluster headaches, among others.³⁸¹

It should nonetheless be recalled that 'science' may be conceptualised differently from one country to another. This issue was particularly visible in 2015

during the negotiation of CND Resolution 58/7³⁸² on strengthening cooperation with the scientific community on drug demand and supply reduction policies. Proposed by the Russian Federation, the resolution was the subject of concerns among civil society groups since the country's discourse around harm reduction, and OST in particular, has failed to recognise available scientific evidence of effectiveness for these interventions. Instead, the Russian Federation has long promoted its science of 'narcology', which draws its roots from Soviet Russian psychiatry.³⁸³ In such contexts, the UNODC, WHO and other UN entities have a key leadership role to play in collating and assessing scientific evidence on drug control.

2.1.3 The right to life

2009 Political Declaration and Plan of Action

Action 22(c): 'Ensure that supply reduction measures are carried out in full conformity with the purposes and the principles of the Charter of the United Nations and international law, the three international drug control conventions and, in particular, with full respect for the sovereignty and territorial integrity of States, the principle of non-intervention in the internal affairs of States and all human rights and fundamental freedoms'

Action 41(c): 'Ensure that measures to control precursors and amphetamine-type stimulants are carried out in full conformity with the purposes and the principles of the Charter of the United Nations and international law, the international drug control conventions and, in particular, with full respect for the sovereignty and territorial integrity of States, the principle of non-intervention in the internal affairs of States and all human rights and fundamental freedoms'

'Although drugs and crime kill, governments should not kill because of them', UNODC Executive Director Foreword of the 2009 Political Declaration³⁸⁴

The right to life, enshrined within Article 3 of the Universal Declaration of Human Rights,³⁸⁵ Article 6 of the International Covenant on Civil and Political Rights,³⁸⁶ and Article 6 of the Convention on the Rights of the Child,³⁸⁷ is the precondition for the full realisation of human dignity and the effective exercise of all human rights.³⁸⁸ The UN Human Rights Committee has stressed that the 'right to life...should not be interpreted narrowly and that

governments should adopt "all positive measures" to "increase life expectancy".³⁸⁹ This includes several elements, particularly a range of economic, social and cultural rights which are essential to meet the basic needs and lead a dignified life.

The death penalty for drug offences

Although the death penalty is not specifically mentioned in the 2009 Political Declaration, international human rights mechanisms and the INCB are unanimous in their conclusion that drug offences do not meet the threshold of 'most serious crimes', which are the only crimes under international law to which the death penalty may conceivably be applied.³⁹⁰ However, 33 jurisdictions worldwide still prescribe capital punishment for drug-related crimes. Although only a minority execute for these offences (see [Table 4](#)),³⁹¹ since 2009 at least 3,940 people were executed for drug offences.³⁹² This figure is likely to amount for only a fraction of those executed because of the under-reporting and secrecy surrounding the practice in various countries – most notably China, where thousands of people are believed to have been executed for drug offences in the past decade.³⁹³

In addition to the serious human rights implications of such an approach, available evidence shows that the death penalty has no measurable impact on deterring involvement in drug-related offences, the prevalence of drug use and drug-related health and social harms. In fact, Asia – where most countries imposing the death penalty for drugs are located – is one of the regions where drug use overall is increasing.³⁹⁴

A growing number of human rights mechanisms, drug control bodies and governments have called for an end to the death penalty for drug offences, including the UNODC³⁹⁵ and the INCB.³⁹⁶ The wide opposition to capital punishment for drugs was evident during the 2016 UNGASS, where 66 member states spoke against the practice.³⁹⁷ Regrettably, as in 2009, no consensus could be achieved between member states on the issue, leading to its omission from the UNGASS Outcome Document.³⁹⁸



Credit: Juan Fernández Ochoa, IDPC

At national level, positive trends have been documented since 2009. The number of reported executions (excluding those carried out in secret) dropped from over 600 in 2010 to 280 in 2017.³⁹⁹ Countries are progressively moving away from the death penalty as a mandatory punishment for drug crimes, either by removing it from their legal system or allowing more discretion for judges when imposing the sentence (e.g. India⁴⁰⁰ and Malaysia⁴⁰¹) or by limiting its scope (e.g. Singapore⁴⁰²). Other initiatives aimed at curbing the use of the death penalty were adopted by Thailand⁴⁰³ and Palestine.⁴⁰⁴ One of the most significant developments was the amendment approved in November 2017 by Iran which raised the minimum quantity of drugs required to incur capital punishment.⁴⁰⁵ This reform had impressive effects, with the number of executions for drug crimes dropping from 242 in 2017 (an average of one execution every 1.5 days), to just three in the first seven months of 2018.⁴⁰⁶

At the same time, however, some governments have revamped their war on drugs approach. In the Philippines, a bill reinstating the death penalty for a wide range of drug-related offences was approved in the House of Parliament and is now sitting in the Senate,⁴⁰⁷ despite the fact that the reintroduction of capital punishment would also contravene the Philippines' obligations under the Second Optional Protocol to the International Covenant on Civil and Political Rights,⁴⁰⁸ an international treaty ratified by the country in 2007 which categorically prohibits executions and commits countries to abolish the death penalty. Similar bills aimed at widening the use of the death penalty for drugs are being considered in Bangladesh⁴⁰⁹ and Sri Lanka.⁴¹⁰ Furthermore, since 2009, countries which had previously abandoned or strongly limited this practice resumed executions – in particular Indonesia and Singapore⁴¹¹ – while other countries, such as Saudi Arabia, continue to execute large numbers of drug offenders each year.

Extrajudicial killings of suspected drug offenders

The recent trend of targeting and killing suspected drug offenders has raised many concerns over violations to the right to life. Such practices have been reported in the Philippines (see [Box 11](#)),⁴¹² Indonesia⁴¹³ and Bangladesh.⁴¹⁴ In Indonesia, the police were involved in the killing of an estimated 79 suspected drug dealers in 2017 – a sharp rise from the 14 killings recorded in 2016 and 10 killings in 2015.⁴¹⁵ In Bangladesh, between May and July 2018, at least 200 people were killed at the hands of the police and more than 25,000 were arrested for suspicion of involvement in the illegal drug trade.⁴¹⁶ The UN High Commissioner

for Human Rights condemned these killings and expressed concern that marginalised communities were being particularly targeted.⁴¹⁷ Similarly, the approach of 'shoot to kill' while enforcing drug laws, in violation of the right to life, has been condemned by the UNODC which concluded that 'Such responses contravene the provisions of the international drug control conventions, do not serve the cause of justice, and will not help to ensure that "all people can live in health, dignity and peace, with security and prosperity"'.⁴¹⁸ The INCB,⁴¹⁹ various UN human rights bodies⁴²⁰ and governments⁴²¹ also condemned the practice of extrajudicial killings as a drug control strategy.

2.1.4 The right to be free from torture and other cruel, inhuman and degrading treatment or punishment

2009 Political Declaration and Plan of Action

Action 6(a): 'Ensure that demand reduction measures respect human rights and the inherent dignity of all individuals and facilitate access for all drug users to prevention services and health-care and social services, with a view to social reintegration'

Action 22(c): 'Ensure that supply reduction measures are carried out in full conformity with the purposes and the principles of the Charter of the United Nations and international law, the three international drug control conventions and, in particular, with full respect for the sovereignty and territorial integrity of States, the principle of non-intervention in the internal affairs of States and all human rights and fundamental freedoms'

The right to be free from torture and other cruel, inhuman and degrading treatment or punishment is enshrined in Article 7 of the International Covenant on Civil and Political Rights⁴²² and the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment.⁴²³ This prohibition is absolute and non-derogable, even in time of public emergency, and can never be justified whether on the basis of 'exceptional circumstances', 'superior orders', 'necessity' or other reason. In 2009, member states committed to ensure that both demand reduction and supply reduction measures would respect human rights. However, a large number of human rights violations associated with drug control efforts have been documented by the UN and civil society between 2009 and 2018. Perhaps in response to these abuses, in 2016 member states committed to 'uphold the prohibition of...torture and other cruel, inhuman

Box 11 Extrajudicial killings in the Philippines

While campaigning for the Philippines' presidential election in 2016, Rodrigo Duterte committed to launch a war against drugs that featured killing people suspected of using or supplying drugs, which he justified to the public by the extensive level of drug-related activities in the country. On the day of his inauguration as president on 31 July 2016, he made a plea to the people: 'If you know of any addicts, go ahead and kill them yourself as getting their parents to do it would be too painful'.⁴²⁴ He also encouraged the police to kill drug offenders and promised them immunity.⁴²⁵

According to the Philippines government, 4,075 'drug personalities' were killed by security forces during drug law enforcement operations in the period 1 July 2016 to 20 March 2018.⁴²⁶ The Philippine National Police reported that an additional 22,983 people were killed from 1 July 2016 to 21 May 2018 – this represents at least 33 people killed each day during this period, in cases classified as 'deaths under inquiry'.⁴²⁷ In total, this amounts to over 27,000 people killed since 1 July 2016.⁴²⁸ Recognising that the reported numbers of people killed are disputed by some NGOs, a project supporting multidisciplinary and evidence-based research on the drug control campaign in the Philippines known as the 'Drug Archive' has collated and analysed data on verified cases of killings from 10 May 2016 to 28 September 2017, which represent only a fraction of the killings.⁴²⁹

During the first 15 months of the Duterte presidency, there were only 19 days where no deaths were reported in the media, including four days in February 2017 after the Philippines National Police drug law enforcement operations were suspended following the kidnapping and murder of a South Korean businessman; and five days in August 2017 after public outrage against the killing of 17-year old Kian delos Santos, where CCTV footage showed him being dragged away by police then shot to death in an alley.⁴³⁰

Reports from civil society organisations also unveiled a network of links between state authorities and unidentified armed persons, and under-the-table payments to police to kill suspects. In addition, 'drug watch lists', used to identify people suspected of using or selling drugs, have

acted as unsubstantiated blacklists, in violation of the right of due process.⁴³¹

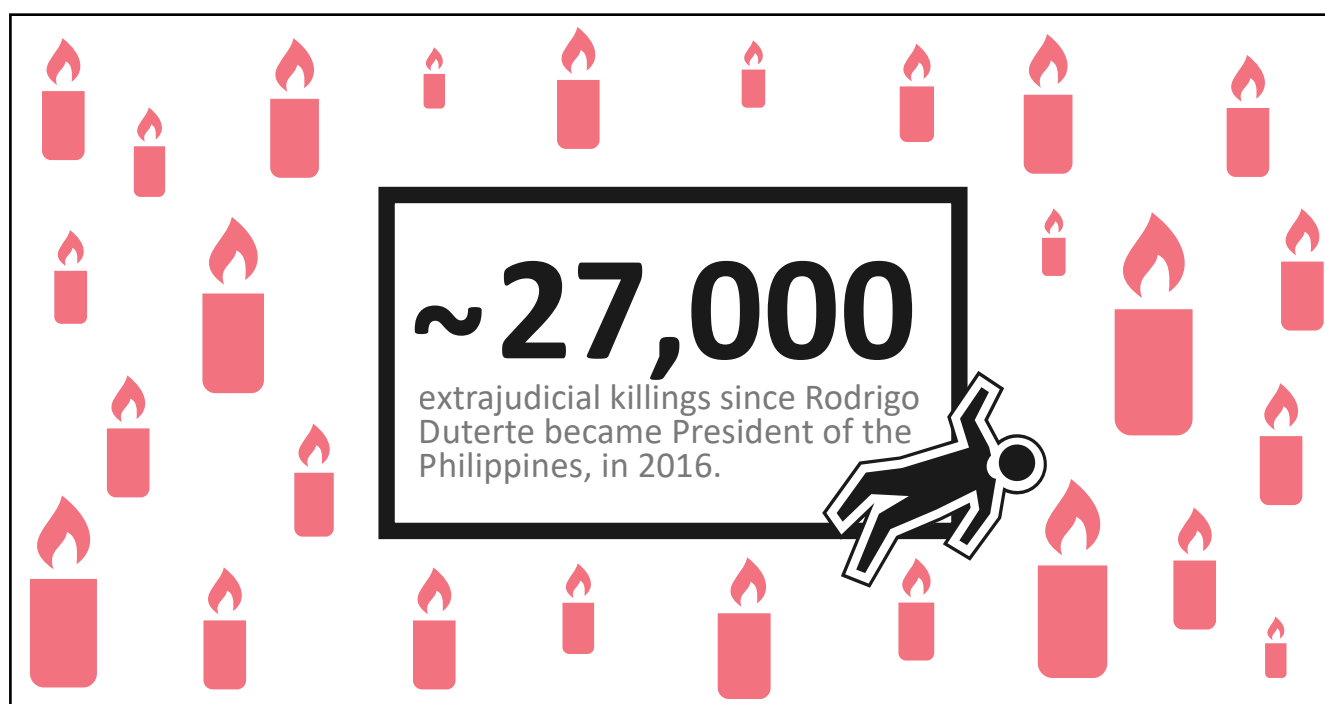
Despite the thousands of people unlawfully killed in police operations or cases of 'deaths under inquiry', as of September 2017 the Philippines Department of Justice reported that prosecutors had only filed 19 murder and homicide cases nationwide in connection with the government's war on drugs, with no convictions.⁴³² The UN High Commissioner for Human Rights has condemned the impunity for extrajudicial killings related to the Philippines' war on drugs, as well as the ongoing threats by Duterte against people suspected of drug-related activities and people working to uphold and protect human rights (including national and international human rights defenders such as Senator Leila de Lima,⁴³³ the Philippines Commission on Human Rights and the UN Special Rapporteur on extrajudicial, summary or arbitrary executions).⁴³⁴

According to civil society organisations, this wave of deliberate and widespread extrajudicial executions, which appear to be systematic, planned and organised by the authorities, may constitute crimes against humanity. In February 2018, the International Criminal Court opened a preliminary examination into whether crimes against humanity had been committed in the Philippines' war on drugs,⁴³⁵ prompting President Duterte to announce, a few weeks later, that the Philippines would withdraw from the Rome Statute.⁴³⁶



Credit: Support. Don't Punish

Memorial during the 2017 Support. Don't Punish Global Day of Action



or degrading treatment or punishment' within the UNGASS Outcome Document.⁴³⁷

Corporal punishment for drug offences

Under the laws and religious practices of several countries, criminal courts and/or administrative bodies may impose corporal punishment for a number of drug offences, either as the main sanction or in addition to a prison sentence. The offences range from simple drug use, to possession of certain amounts of drugs and drug trafficking. Corporal punishments can include caning, whipping, lashing, flogging, stoning and bodily mutilation. Such practices have been reported in Brunei Darussalam, Indonesia, Iran, Malaysia, the Maldives, Nigeria, Saudi Arabia, Singapore, the United Arab Emirates and Yemen.⁴³⁸ Brunei Darussalam, Malaysia, Saudi Arabia and Singapore were also reported to use corporal punishment on children.⁴³⁹ The intensity of application of corporal punishment varies from country to country, with Singapore and Malaysia being some of the most active states in the number of cases for which corporal punishment is applied.⁴⁴⁰ This practice has been condemned by UN human rights bodies and entities as amounting to cruel, inhuman and degrading punishment and contravenes the absolute prohibition of torture.⁴⁴¹

Compulsory detention as 'treatment'

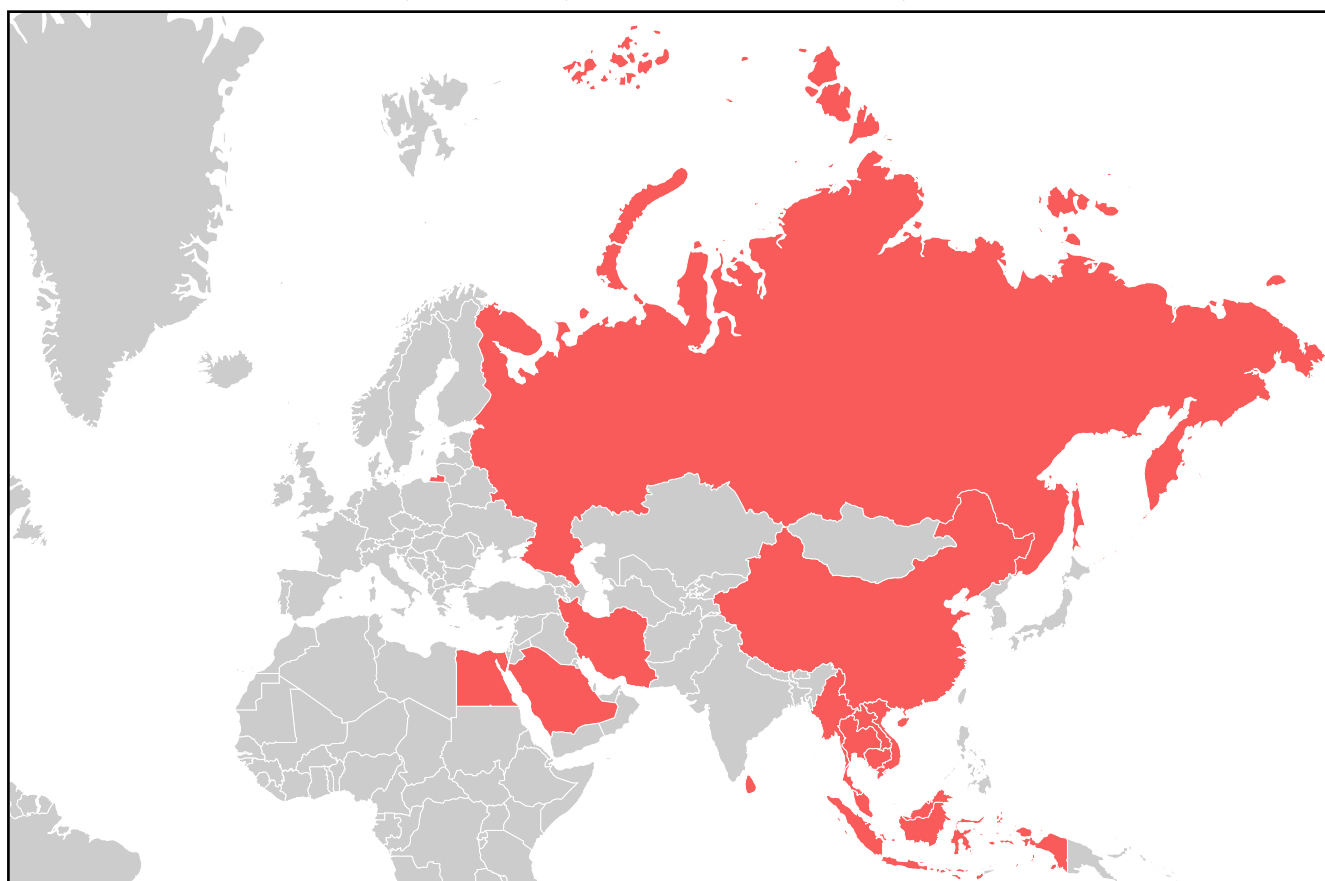
In 2012, 12 UN entities – including the UNODC, WHO, UNAIDS, UNICEF, UN Women, OHCHR and others – called for the closure of compulsory drug detention centres, concluding that they 'raise

human rights issues and threaten the health of detainees, including through increased vulnerability to HIV and tuberculosis (TB) infection.'⁴⁴² The UN Working Group on Arbitrary Detention found that compulsory detention regimes for the purposes of drug 'rehabilitation' through confinement or forced labour are inherently arbitrary.⁴⁴³

However, various countries retain this practice today: Brunei Darussalam, Cambodia, China, Egypt, Indonesia, Iran, Lao PDR, Malaysia, Myanmar, Russia, Saudi Arabia, Singapore, Sri Lanka, Thailand and Vietnam (see Figure 7).⁴⁴⁴ Several Latin American and Caribbean countries also use some form of compulsory detention, although these practices are generally not sanctioned by national laws and are often run by private actors, including by religious groups and other non-governmental organisations with little or no supervision by state authorities. This is the case in Brazil, the Dominican Republic, Ecuador, Guatemala, Mexico, Peru and Puerto Rico.⁴⁴⁵ Numerous studies from NGOs, UN agencies and academics have reported widespread cases of human rights violations associated with compulsory detention, including lack of due process, inhuman, cruel and degrading treatment (including beatings, whipping and flogging) sometimes amounting to torture, arduous physical exercises, forced labour, denial of medical treatment, imposition of unscientific and abusive methods of 'treatment', and humiliation of various kinds.⁴⁴⁶

In 2015, the UNODC issued a discussion paper providing recommendations to support member states to transition from compulsory detention to

Figure 7. Map of countries officially (including by law) engaged in compulsory detention of people who use drugs



Credit: Juan Fernandez Ochoa, IDPC

voluntary community-based treatment.⁴⁴⁷ The UN Special Rapporteur on the right to health has highlighted the mounting evidence that healthcare and support in community settings yield better health outcomes, particularly for marginalised groups.⁴⁴⁸ However, little progress has been made to close down the centres since 2009.

Violence and ill-treatment by law enforcement agencies

In various countries around the world, UN entities and civil society organisations have documented widespread cases of violence, excessive use of force and ill-treatment of people who use drugs and drug offenders at the hands of the police or the military. Furthermore, in several contexts the police have adopted militarised drug law enforcement strategies, including through training, equipment and techniques to dismantle the illegal drug market. This has been the case, for instance, in countries like Argentina, Brazil and Mexico, where the armed forces are granted increasing powers to tackle the drug trade, resulting in an exacerbation of violence.

In the midst of Mexico's drug war, between 2011 and mid-2014, 3,260 complaints of torture, enforced disappearances and other human rights violations have been attributed to the armed forces – with only a handful being investigated.⁴⁴⁹ In 2010, the Special Rapporteur on Torture reported that in Indonesia

drug offenders were tortured, including through beatings, to provide information about their drug suppliers.⁴⁵⁰ Another study found that people who use drugs in Russia were regular victims of physical violence, ill-treatment and rape at the hands of law enforcement officers to obtain information and 'facilitate "confession"'.⁴⁵¹ The UN Special Rapporteur on Torture also documented cases of people dependent on drugs being denied OST 'as a way of eliciting criminal confessions through inducing painful withdrawal symptoms', which is recognised as a form of torture.⁴⁵² The UN Committee against Torture has recently raised concerns over this practice.⁴⁵³ Additional studies found that women are particularly at risk of physical and mental abuse at the hands of the police.⁴⁵⁴ In Zimbabwe⁴⁵⁵ and Mexico⁴⁵⁶ for example, women who use drugs are regularly asked for sexual favour by the police in exchange for their release.



Credit: 2011 Private Human Rights Watch

Table 4. Global overview of sanctions against drug offenders that contravene human rights⁴⁵⁷

	Forced urine testing for traces of drug use	Compulsory registration of people who use drugs	Duty to report drug use to third parties	Compulsory detention centres for people who use drugs	Corporal punishment for drug offenders	Death penalty for drug offences			
						High application	Low application	Symbolic application	Insufficient data
Azerbaijan	x	x							
Bangladesh	x							x	
Bahrain								x	
Brunei		x		x	x			x	
Cambodia	x	x		x					
China	x	x		x		x			
Cuba								x	
Egypt				x			x		
Georgia	x								
India		x						x	
Indonesia	x	x	x	x	x	x			
Iran	x			x	x	x			
Iraq							x		
Japan		x							
Kazakhstan	x	x							
Kuwait								x	
Kyrgyzstan	x	x							
Lao PDR	x	x		x				x	
Libya									x
Malaysia	x	x		x	x	x			
The Maldives					x				
Myanmar	x	x		x				x	
Nigeria					x				
North Korea									x
Oman								x	
Pakistan	x	x					x		
Palestine							x		
Philippines	x		x						
Qatar								x	
Russia				x					
Saudi Arabia				x	x	x			
Singapore	x			x	x	x			
South Korea	x							x	
South Sudan								x	
Sudan								x	
Syria									x
Sri Lanka	x			x				x	
Taiwan							x		
Tajikistan	x	x							
Thailand	x			x			x		
Turkey	x								
Turkmenistan	x	x							
Vietnam	x		x	x		x			
UAE								x	
United States								x	
Uzbekistan	x	x							
Yemen									x

Note that the list of countries for each category may not be exhaustive

2.1.5 The right to liberty and to be free from arbitrary detention

2009 Political Declaration and Plan of Action

Action 6(a): 'Ensure that demand reduction measures respect human rights and the inherent dignity of all individuals and facilitate access for all drug users to prevention services and health-care and social services, with a view to social reintegration'

Action 15(a): 'Working within their legal frameworks and in compliance with applicable international law, consider allowing the full implementation of drug dependence treatment and care options for offenders, in particular, when appropriate, providing treatment as an alternative to incarceration'

Action 22(c): 'Ensure that supply reduction measures are carried out in full conformity with the purposes and the principles of the Charter of the United Nations and international law, the three international drug control conventions and, in particular, with full respect for the sovereignty and territorial integrity of States, the principle of non-intervention in the internal affairs of States and all human rights and fundamental freedoms'

According to Article 9 of the International Covenant on Civil and Political Rights,⁴⁵⁸ the right to liberty entails that no one shall be subjected to arbitrary arrest or detention, and that no one shall be deprived of their liberty except on such grounds and in accordance with such procedure as are established by law.⁴⁵⁹ Under the right to liberty, people who are arrested must be informed of the reasons of their arrest and notified of their rights at time of arrest, and must be brought promptly before the judge. Everyone deprived of their liberty has the right to challenge the lawfulness of their detention before a court, and a person unlawfully detained has the right to reparation, including compensation.

The UN Working Group on Arbitrary Detention found various instances in which people who use drugs were 'particularly at risk of arbitrary detention',⁴⁶⁰ and declared that compulsory detention for the purpose of drug 'treatment' was 'inherently arbitrary'.⁴⁶¹ Civil society studies have supported these findings. A report on Russia, for instance, found that people who use drugs were regularly victims of arbitrary arrest, planting of evidence to expedite arrest

and extortion of money or drugs for police gains.⁴⁶² In response, a person who uses drugs in Russia brought his complaint of arbitrary detention all the way to the UN Working Group on Arbitrary Detention (in the case of Matveev v. Russian Federation) which concluded that Russia had violated his rights under the International Covenant on Civil and Political Rights.⁴⁶³ In Cambodia, the drug war launched in January 2017 has resulted in 17,700 people arrested for suspected drug activities – an 80% increase from the previous year.⁴⁶⁴ In Bangladesh, more than 13,000 people were arrested between May and June 2018.⁴⁶⁵

The UN Working Group on Arbitrary Detention also concluded that 'the right to liberty of persons in Article 9 of the International Covenant on Civil and Political Rights requires that states should have recourse to deprivation of liberty only insofar as it is necessary to meet a pressing societal need, and in a manner proportionate to that need'. Regarding pretrial detention, the Working Group 'noted with concern the practice of over-incarceration...as well as the factors that lead to over-incarceration, including detainees' ethnic or social origin, poverty and social marginalization'.⁴⁶⁶ According to international human rights law and standards, pre-trial detention must be an exceptional measure and based on an individualised determination that it is reasonable and necessary only when there is a substantial risk of flight, harm to others or interference with the evidence or investigation that cannot be allayed by other means. The UN Human Rights Committee has further established that pre-trial detention should not be mandatory for any particular crime nor should it be ordered for a period based on the potential sentence.⁴⁶⁷

The same year, the UN CCPCJ estimated that one in five prisoners worldwide was incarcerated for a drug offence.⁴⁶⁸ In various regions, women have been particularly affected, with over half of women in prison being incarcerated for drug offences. Although they continue to represent a small proportion of the general population, female prisoners are the fastest growing prison population, and this is driven by overly punitive drug laws (see [Box 12](#)).⁴⁶⁹ The UN CCPCJ also concluded that the overwhelming majority of those in prison for drug offences were accused of drug use or drug possession for personal use. The rest are generally accused of low-level dealing and micro-trafficking, with a minor proportion imprisoned for high-level, violent drug offences. In Colombia, for example, only about 2% of all prisoners convicted of drug offences are medium to high-ranking figures.⁴⁷⁰

1 in 5

prisoners worldwide are incarcerated for drug offences



In some parts of the world, **over 80% of women** incarcerated are serving sentences for drug-related offences.

~83%
serve sentences for drug possession for personal use



Credit: Juan Fernandez Ochoa, IDPC

These minor, non-violent drug offences are often punished with longer prison sentences than for violent offences such as rape or murder. In Bolivia, for example, the maximum penalty for drug trafficking is 25 years, compared to 20 years for homicide and 15 years for rape.⁴⁷¹ In various countries, drug laws and criminal codes impose mandatory minimum sentences for drug offences, preventing any flexibility on the part of the judge to impose less severe punishment for first-time, non-violent offences. The disproportionate nature of criminal sanctions for drug offences not only violates the right to liberty; it can also undermine the rule of law where criminal systems have to absorb a high number of minor offences instead of focusing scarce resources on crimes that have a higher impact on society. Over-incarceration for drug offences can also exacerbate poverty and marginalisation, as many people involved in low-level dealing or micro-trafficking are in a situation of vulnerability (see [Box 12](#)).

The sheer number of people incarcerated for drug offences, as well as the proportion of people held in pre-trial detention for drug crimes, have contributed to severe prison overcrowding and dire conditions in detention in many parts of the world – with little progress made to tackle this phenomenon since 2009. In 2015, the OHCHR raised concerns over ‘reports of persons detained for drug-related offences not being registered or promptly brought before a judge’, adding that ‘In some States...an arrested person suspected of a drug-related offence can be kept in custody without being charged for a substantially longer time than a person detained for other offences can be.’⁴⁷² In countries like Bolivia, Brazil, Ecuador

and Mexico, for example, pre-trial detention is mandatory for all drug offences, whether of minor or high-level nature, and people can await trial for months up to several years.⁴⁷³ This runs counter to the recommendations by the UN Working Group on Arbitrary Detention to ‘ensure that persons are not held in pretrial detention for periods longer than those prescribed by law or proportionate, and *that they are promptly brought before a judge*’ (emphasis added).⁴⁷⁴ The principles of proportionality of sentencing and of alternatives to incarceration are welcome additions within the UNGASS Outcome



Credit: Adam Schaffer, WOLA

Box 12 The mass incarceration of women for drug offences in Latin America

The 2009 Political Declaration and Plan of Action each have only one reference to women, and neither acknowledges the growing incarceration of women for drug-related offences. According to the World Female Imprisonment List, more than 714,000 women and girls are currently being held in penal institutions worldwide.⁴⁷⁶ The number of women and girls in prison has increased by 53% between mid-2000 and mid-2016, a period in which the global male prison population increased by only 20%.⁴⁷⁷ In the most extreme example of Brazil, the country's female prison population increased by 342% between 2000 and 2016⁴⁷⁸ and women incarcerated for drug offences account for about 60% of the total female prison population.⁴⁷⁹ The highest levels of incarceration of women, however, can be found in East and South East Asia, where the mass incarceration of individuals charged with low-level, non-violent drug offences has led to severe prison overcrowding. As of 2015, over 47,000 women were behind bars in Thailand, 80% of whom were convicted of drug offences.⁴⁸⁰

In Latin America, most women are arrested for first time, non-violent, low-level but high-risk drug-related activities, such as small-scale drug dealing or transporting drugs, or for simple drug use – and generally engage in illegal drug activities because of poverty, lack of opportunities and/or coercion. They often have little or no education and live in conditions of poverty. A large number are single mothers, and the sole care provider of their children because of entrenched gender norms.⁴⁸¹ They may also need harm reduction or treatment services for drug dependence, mental health issues or physical problems, which are often hard to access in prison. Most have suffered some form of sexual violence before and/or during their incarceration.⁴⁸² Their incarceration can have severe and long-lasting consequences not only for themselves, but also for their families and communities.⁴⁸³

The 'UN Rules for the Treatment of Women Prisoners and Non-Custodial Measures for Women Offenders' (the Bangkok Rules), adopted in December 2010 by the UN General Assembly, were instrumental in recognising the specific characteristics and needs of women deprived of their liberty.⁴⁸⁴ Those rules, as well as reports from the UN Special Rapporteur on violence against women⁴⁸⁵ and the Committee on the Elimination of all forms of Discrimination against Women,⁴⁸⁶ have called upon governments to develop gender-sensitive alternatives to incarceration. In Vienna, it was not until March 2016 that the CND adopted a landmark resolution (Resolution 59/5) on 'Mainstreaming a gender perspective in drug-related policies and programmes', which recognised the many risks faced by women in the illegal drug trade and called on member states to adopt gender-sensitive drug policies and programmes.⁴⁸⁷ The UNGASS Outcome Document was a significant step forward on gender issues, by highlighting the importance of promoting gender-sensitive drug policies, and recognising both the particular vulnerabilities and specific needs of women in primary care and treatment programmes, as well as within the criminal justice system. With regards to incarceration, operational paragraph 4.n encourages 'the taking into account of the specific needs and possible multiple vulnerabilities of women drug offenders when imprisoned', in line with the Bangkok Rules.⁴⁸⁸

Nationally, since 2009 only a handful of countries have adopted gender sensitive policies to address the high rates of incarceration of women for drug offences. Today, there is an urgent need to ensure proportionate penalties for drug offences, allowing for the consideration of mitigating factors such as socio-economic marginalisation, being the sole care provider of dependents, and drug dependence, and make better use of gender-sensitive alternatives to incarceration for minor offenders.

2.1.6 The right to a fair trial and due process

2009 Political Declaration and Plan of Action

Action 6(a): 'Ensure that demand reduction measures respect human rights and the inherent dignity of all individuals and facilitate access for all drug users to prevention services and health-care and social services, with a view to social reintegration'

Action 22(c): 'Ensure that supply reduction measures are carried out in full conformity with the purposes and the principles of the Charter of the United Nations and international law, the three international drug control conventions and, in particular, with full respect for the sovereignty and territorial integrity of States, the principle of non-intervention in the internal affairs of States and all human rights and fundamental freedoms'

Action 41(c): 'Ensure that measures to control precursors and amphetamine-type stimulants are carried out in full conformity with the purposes and the principles of the Charter of the United Nations and international law, the international drug control conventions and, in particular, with full respect for the sovereignty and territorial integrity of States, the principle of non-intervention in the internal affairs of States and all human rights and fundamental freedoms'

The right to due process and a fair trial – protected in Article 10 of the Universal Declaration of Human Rights⁴⁸⁹ and Articles 14 and 16 of the International Covenant on Civil and Political Rights⁴⁹⁰ – includes the right to a fair and public hearing by a competent, independent and impartial tribunal established by law; to be presumed innocent until proven guilty; to be tried without delay; to access interpreters, consular assistance and legal aid; and to receive prompt and detailed information and legal assistance in a language and format that is accessible.

The recognition, in the UNGASS Outcome Document, of the need to 'Promote and implement effective criminal justice responses to drug-related crimes to bring perpetrators to justice that ensure legal guarantees and due process safeguards...and ensure timely access to legal aid and the right to a fair trial'⁴⁹¹ has been a significant step forward in ensuring more human rights protections in demand and supply reduction strategies. This operational recommendation is particularly relevant in light of the recent surge in extrajudicial killings of people

suspected of engaging in illegal drug activities in South and South East Asia. The UN High Commissioner for Human Rights characterised this practice as 'dangerous...and indicative of a total disregard for the rule of law'.⁴⁹² The compulsory detention of people who use drugs also raises concerns over the lack of due process associated with this practice.⁴⁹³

In less extreme cases, the right to a fair trial and due process is hampered in a number of ways for people accused of drug offences. The OHCHR, for instance, reported country cases where a person is automatically presumed guilty of drug trafficking in specific conditions, thereby reversing the burden of proof in criminal proceedings.⁴⁹⁴ In several countries, trials rely on statements made under coercion during police investigation.⁴⁹⁵ In other cases, investigations, arrests and house searches are conducted without judicial authorisation and with reports of incommunicado detention without charges.⁴⁹⁶

2.1.7 The rights of indigenous peoples

2009 Political Declaration and Plan of Action

Action 22(e): 'Promote supply reduction measures that take due account of traditional licit uses, where there is historical evidence of such use, as well as environmental protection, in conformity with the United Nations Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances of 1988'

The UN Declaration on the Rights of Indigenous Peoples (UNDRIP), adopted in 2007, reinforces the basic cultural rights embedded in Article 27 the Universal Declaration of Human Rights⁴⁹⁷ and Article 15 of the 1966 International Covenant on Economic, Social and Cultural Rights.⁴⁹⁸ In particular, it establishes that indigenous peoples have the right not to be subjected to forced assimilation or destruction of their culture (Article 8); to practice and revitalise their cultural traditions and customs (Article 11); to be secure in the enjoyment of their own means of subsistence and development and to engage freely in all their traditional and other economic activities (Article 20); and to maintain, control, protect and develop their cultural heritage (Article 31).⁴⁹⁹ According to Julian Burger, former coordinator of the OHCHR Indigenous Peoples and Minorities Unit, this 'gives indigenous peoples the possibility of continuing to produce crops and plants that they have traditionally grown for their own religious, medicinal, or customary purposes, and which constitute a part of their cultural practice and identity'.⁵⁰⁰



Aymara women collectively harvesting coca in Bolivia's Nor Yungas province

Perhaps as a result of the inherent contradictions between indigenous rights and the international drug control regime (see [Box 13](#)), only a handful of member states have adopted laws and regulations to protect the rights of indigenous groups to grow and use controlled substances. The most emblematic example is Bolivia's constitutional protection of the traditional use of the coca leaf. Other examples include the protection of coca use among indigenous communities in Colombia, Peru and Argentina;⁵⁰¹ the 2015 legislation in Jamaica allowing the religious use of cannabis among the Rastafari;⁵⁰² ayahuasca use for traditional and religious purposes in Brazil, Peru, Colombia and Canada (in the latter, limited to the Ceu do Montreal religious group); the ancestral use of peyote among Native Americans in the USA; and the traditional use of khat in Ethiopia, Somalia and Yemen.⁵⁰³

The 1989 Indigenous and Tribal Peoples Convention (No. 169) also enshrines indigenous peoples' right to free prior and informed consent in all matters that affect them.⁵⁰⁴ In practice, drug control strategies in indigenous peoples' lands have largely been designed and implemented without consultations with local communities, and have mostly consisted in forced crop eradication campaigns, as will be further discussed [below](#).

2.1.8 The right to be free from discrimination

2009 Political Declaration and Plan of Action

Action 2(g): 'Develop and implement, in cooperation with international and regional agencies, a sound and long-term advocacy strategy, including harnessing the power of communication media, aimed at reducing discrimination that may be associated with substance abuse, promoting the concept of drug dependence as a multifactorial health and social problem and raising awareness, where appropriate, of interventions based on scientific evidence that are both effective and cost-effective'

The right to be free from discrimination is recognised in the Universal Declaration of Human Rights,⁵⁰⁵ the International Covenant on Civil and Political Rights,⁵⁰⁶ the International Covenant on Economic, Social and Cultural Rights,⁵⁰⁷ as well as the International Convention on the Elimination of All Forms of Racial Discrimination,⁵⁰⁸ the Convention on the Elimination of All forms of Discrimination Against Women⁵⁰⁹ and the Convention on the Rights of Persons with Disabilities.⁵¹⁰

Box 13 Addressing the tensions between the rights of indigenous groups and UN drug control obligations

There is an undeniable conflict between the obligations imposed by the UN drug control system and indigenous rights – which is reflected in action 22(e). When the UN drug control regime was established, the rights of indigenous peoples had not yet acquired the international legal recognition that they have today. Indigenous peoples had no say at all in the negotiation of the drug treaties, while today consultation and consent are accepted principles for all matters of law and policy that impact indigenous peoples.

The Single Convention allowed ‘transitional reservations’ for the traditional uses of opium, coca leaf and cannabis (Article 49), but by December 1989 the chewing of coca leaf, the use of cannabis in religious ceremonies, and all other non-medical indigenous practices involving these plants were to be abolished. The 1971 Convention on Psychotropic Substances addresses another range of substances and departs slightly from the zero-tolerance regime imposed for ‘narcotic drugs’ by leaving legal space for the use of ‘psychotropic substances’ in religious ceremonies, specifically for the peyote cactus, hallucinogenic mushrooms and ayahuasca (Article 32.4). More importantly, plants containing psychotropic substances were not brought under international control; only the extracted alkaloids are included in the 1971 Schedules.⁵¹¹

Subsequent diplomatic efforts led to the inclusion of Article 14.2 in the 1988 Convention stating that measures to eradicate the cultivation of coca, opium poppy and cannabis ‘shall respect fundamental human rights and shall take due account of traditional licit uses, where there

is historic evidence of such use’. However, the same article specifies that any measures under the 1988 Convention ‘shall not be less stringent than the provisions applicable to the eradication of illicit cultivation of plants containing narcotic and psychotropic substances’ under the 1961 and 1971 treaties (an obligation further reinforced by Article 25⁵¹²). Therefore, while the insertion of the first and only mention of human rights across the three drug conventions was politically significant, its legal standing remains contentious.

Although the 2009 Political Declaration was adopted only two years after the adoption of the UNDRIP, it made no mention of it and kept with the contradictions enshrined in the 1988 Convention. At the same time the Political Declaration was being adopted, the UN Permanent Forum on Indigenous Issues ruled that certain provisions of the 1961 Convention were ‘inconsistent with the rights of indigenous peoples to maintain their traditional health and cultural practices’ and recommended that those treaty articles ‘be amended and/or repealed.’⁵¹³ In 2016, whilst referring briefly to UNDRIP, the UN-GASS Outcome Document once again failed to address the contradictions between indigenous rights and international drug control obligations.⁵¹⁴ In his UNGASS statement, the UN High Commissioner for Human Rights, Zeid Ra’ad Al Hussein, stated that the language regarding indigenous rights in the 2016 document was ‘ambiguous’, concluding that ‘it would have been better if it were clearly indicated that indigenous peoples should be allowed to use drugs in their traditional, cultural or religious practices when there is historical basis for this.’⁵¹⁵

The high level of stigma and discrimination people who use drugs are facing severely hampers their access to life-saving services and increases their risks of contracting infections. Data suggests that women who use drugs are particularly vulnerable to stigma and discrimination as they are seen as breaking with the traditional image of the woman as a care giver.⁵¹⁶ An additional layer of discrimination exists for people of colour. In the UK, for instance, it is estimated that black people are nine times more likely to be stopped and searched than white people,

even though their prevalence of drug use is lower than for white people.⁵¹⁷

In recognition of these issues, the UN released a joint statement on ‘ending discrimination in health-care settings’ in 2017, calling on member states to review and strengthen their drug laws to prohibit discrimination in the provision of healthcare, repeal punitive laws that have negative health outcomes, including the criminalisation of drug use and possession of drugs for personal use, and strengthen

policies, regulations and standards related to the prevention of discrimination on all grounds in healthcare settings.⁵¹⁸ It is worth noting here that the UNODC is not among the 12 signatory UN agencies and entities. In 2018, the CND adopted its first ever resolution on the need to address the stigma associated with drug use: Resolution 61/11 'Promoting non-stigmatizing attitudes to ensure the availability of, access to and delivery of health, care and social services for drug users'.⁵¹⁹

Although limited to a small number of countries, several interventions have recently been developed with a focus on reducing stigma and improving access to healthcare. The 'Stop the Stigma' campaign,

launched by Citywide Drug Crisis in Ireland, uses information sharing to break down stigma and promote respect and dignity for people who use drugs, support community programmes, understand the complexity of dependence and end the criminalisation of people who use drugs.⁵²⁰ Similarly, the Vancouver Canucks hockey team and the provincial Ministry of Mental Health and Addictions launched the 'Stop overdose' campaign in 2018 in the Province of British Columbia, Canada. As part of this programme, US\$ 322 million are being invested over three years to reduce stigma, show the human face of people who use drugs and provide a health and social response to drug use.⁵²¹

2.2 Promoting peace and security

Following the devastation of the Second World War, one of the core goals of the UN in 1945 was to maintain international peace and security. The UN and its member states aimed to achieve this objective by working to prevent conflict, helping parties in conflict to make peace, peacekeeping, and creating the conditions to allow peace to hold and flourish. This section will assess how drug control in the past decade has contributed to promoting and consolidating peace and security worldwide.

2.2.1 The 'balloon effect' and escalating levels of violence

2009 Political Declaration and Plan of Action

Action 22(c): 'Ensure that supply reduction measures are carried out in full conformity with the purposes and the principles of the Charter of the United Nations and international law, the three international drug control conventions and, in particular, with full respect for the sovereignty and territorial integrity of States, the principle of non-intervention in the internal affairs of States and all human rights and fundamental freedoms'

Action 24(g): 'Implement strategies to disrupt and dismantle major organizations involved in trafficking in narcotic drugs and psychotropic substances and to address emerging trends'

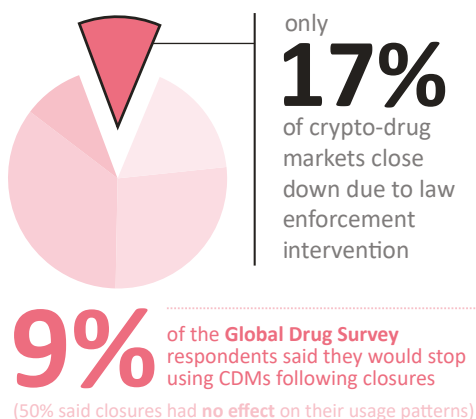
Strategies aiming to dismantle major trafficking hubs and routes, cultivation areas or eradicate a certain substance have generally resulted in market changes, rather than an overall reduction in illegal drug activities globally. The phenomena of 'geographical' and 'substance' displacement resulting from drug control operations had already been identified in the 2008 World Drug Report, and data collected by the UNODC between 2009 and 2018 have confirmed this trend. For instance, crackdowns on opium have led to reductions in cultivation in South East Asia, but opium cultivation has surged in Afghanistan which is now producing 86% of the world's opium (see [Box 14](#)).⁵²² Opium cultivation also went up in Mexico, which is the main supplier for the growing US heroin market.⁵²³ Meanwhile, people who use drugs in East and South East Asia have been drawn towards pharmaceutical opioids and ATS which are often more available than heroin.⁵²⁴

Similarly, in the Andean region, while Bolivia has seen a consistent reduction in coca cultivation since 2009, production has largely increased in Colombia since 2014 – and overall, the global area cultivated has increased by 30% between 2009 and 2016 (see Figure 9). Drug control operations to shut down retail markets for substances like cocaine, ecstasy, heroin and cannabis in Europe and North America have also led to hundreds of synthetic NPS flooding onto the market – with increasing levels of overall drug use⁵²⁵ and, in some cases, elevated levels of drug-related harm compared to more traditional drugs.

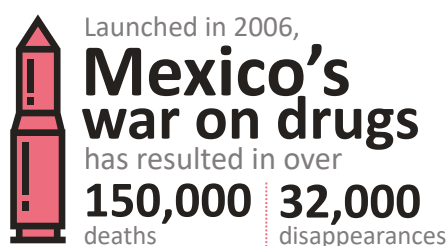
Instead of redressing this situation, policing and militarised drug control campaigns have generally

Assessing progress on Peace and security

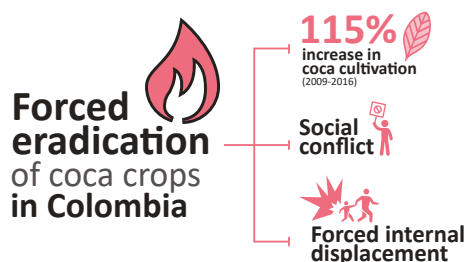
Crypto-drug markets



War on drugs and violence



Eradication and social conflict



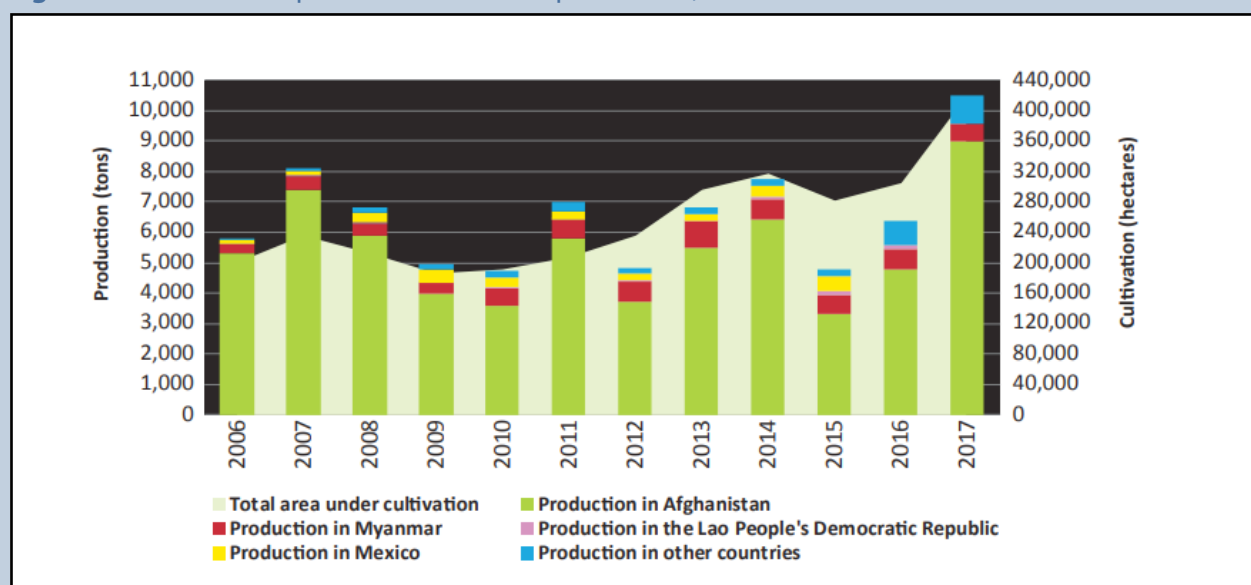
Box 14 Unprecedented levels of opium cultivation in Afghanistan

When the Political Declaration and its Plan of Action were devised in 2009, Afghan poppy cultivation stood at 123,000 hectares and potential opium production at 6,900 tons.⁵²⁶ According to the latest annual report produced by the UNODC and the Afghan Ministry of Counter Narcotics, the opium industry reached unprecedented levels in 2017, with an area of 328,000 hectares under cultivation and potential opium production up to 9,000 tons (see Figure 8).⁵²⁷ Cultivation of poppy increased by 63% since 2016 and passed the previous highest level (in 2014) by 46%, or 104,000 hectares. Potential production of opium increased by 87% between 2016 and 2017. This is despite sustained and intensive intervention on the part of the international community – including regular CND resolutions on the issue⁵²⁸ – and the Afghan government to curb opium cultivation over the past decade.

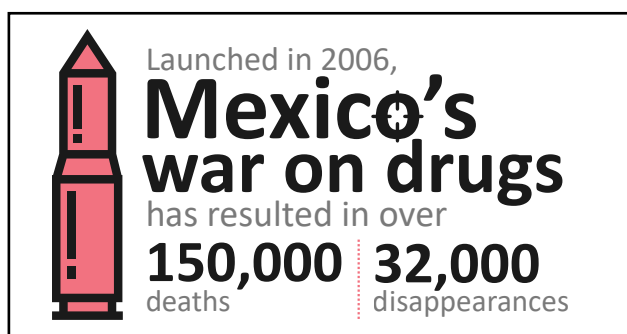
The failure to curb illegal opium cultivation in Afghanistan can be explained by a number of reasons. First and perhaps most importantly, the rise in illegal cultivation reflects the progressive erosion of the Afghan government control, influence and presence in recent years, and the continued and the progressive deterioration in security and political uncertainty in the aftermath of the 2014 presidential election.⁵²⁹ Secondly, the global demand for drugs derived from opium has continued to drive production in the country, especially with the decline in

opium poppy cultivation in the Golden Triangle region (Thailand, Myanmar and Laos PDR). Thirdly, drug control efforts in the country have mainly consisted of alternative development programmes focused on crop eradication and the replacement of opium poppy with other licit crops (e.g. wheat) – but with limited success as the country's climate makes it well suited for poppy cultivation relative to other crops. In the absence of more lucrative alternatives, and with the reduction in international aid for broader socio-economic development in rural areas, opium production remains at the heart of the Afghan economy with thousands of families relying on it to survive.⁵³⁰ In its 2018 World Drug Report, the UNODC concluded that the large-scale production of opiates was likely to 'fuel further instability and insurgency and increase funding to terrorist groups in Afghanistan', and to further 'constrain the development of the licit economy and potentially fuel corruption'.⁵³¹ However, the UNODC pointed out elsewhere that the opium economy also stimulated the wider, licit rural economy as 'Afghan farmers purchase food, have medical expenses, and purchase daily needs products. These expenses – paid from opium money – benefited local bakers, butchers and other small-scale businesses in rural Afghanistan'.⁵³² Tackling the illegal cultivation of opium in the country therefore necessitates a thorough understanding of these complex development and peacekeeping dynamics.

Figure 8. Evolution in opium cultivation and production, 2006-2017⁵³³



Credit: UNODC World Drug Report 2018, Booklet 3



Credit: Juan Fernandez Ochoa, IDPC

undermined peace and security. The emergence of new trafficking routes in developing or fragile states where governance is weak has contributed to destabilising affected countries, undermining the rule of law and facilitating high-level corruption. This has been observed in several West African countries, with Mali, Niger, Nigeria and Guinea-Bissau now recognised as major trafficking hubs, where the collusion between high-level officials and drug traffickers constitutes a major threat to security, governance and development.⁵³⁴ In South East Asia, punitive drug control policies aiming at curbing the expanding market for ATS have translated into an escalation in violence and human rights abuses, including extrajudicial killings. On the other side of the world, Mexico launched a militarised war on drugs in 2006, which has caused over 150,000 drug trade-related deaths⁵³⁵ and more than 32,000 disappearances.⁵³⁶ Between 2011 and 2015, 282,300 people were internally displaced as a consequence of violence,⁵³⁷ and 12,120 drug-related kidnappings

were reported between 2009 and April 2018.⁵³⁸ In Brazil, violent encounters between drug traffickers and security forces in Rio's favelas have led to 5,400 killings between 2009 and 2016.⁵³⁹ In Colombia, forced crop eradication campaigns have led to violent clashes with the police and the military and millions of people internally displaced (see [Box 15](#)).⁵⁴⁰

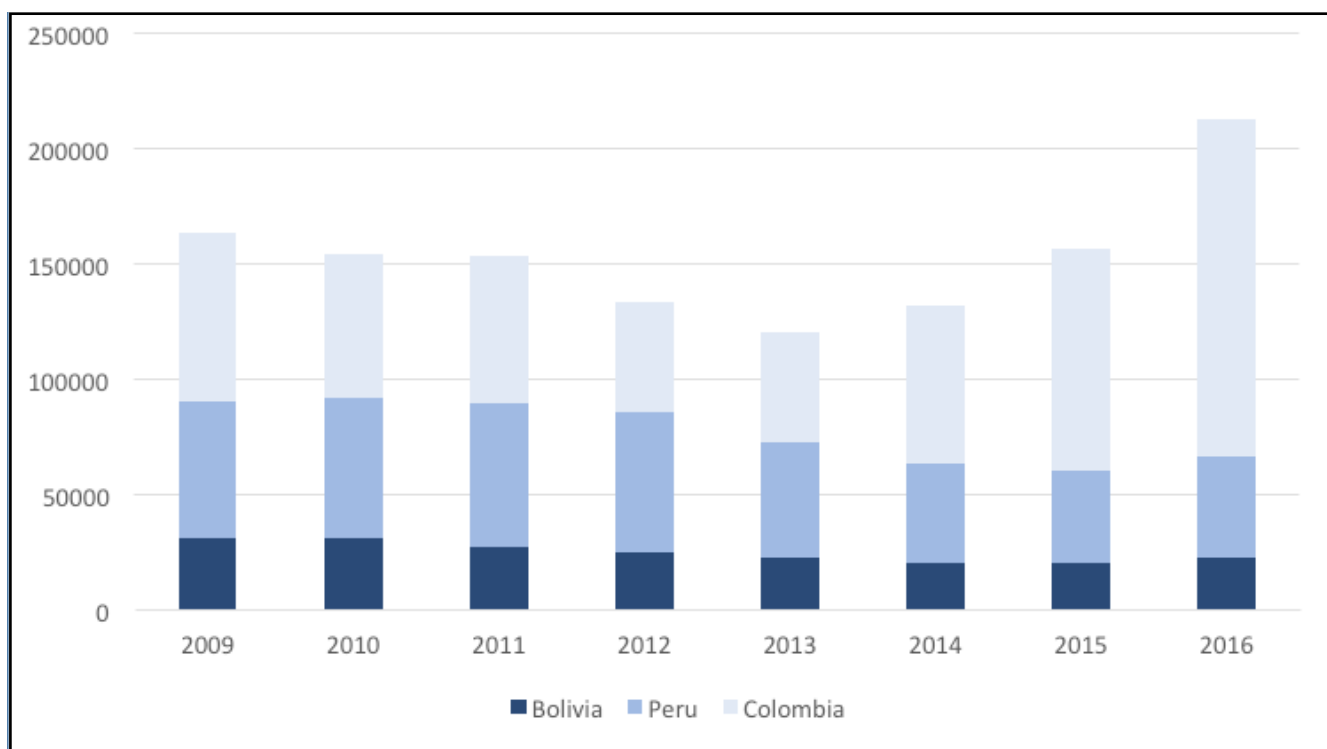
The focus on policing and militarised drug control operations has also shifted often scarce resources away from health and development programmes towards the police and the military. Recognising the severe consequences of this approach, prominent academic institutions, NGOs, UN agencies and various national-level policy makers have engaged in strategic discussions on how to modernise drug law enforcement. Illegal drug markets are not inherently violent, and although drug control may not be able to curb the scale of the illegal drug trade, it might help shape the market in a way that minimises the harms caused to affected communities and society as a whole.⁵⁴¹

2.2.2 The rise of crypto-drug markets

2009 Political Declaration and Plan of Action

Action 36(a): 'Address through concerted action the illegal sale of preparations containing amphetamine-type stimulants via the Internet and the misuse of postal and courier services for smuggling such preparations'

Figure 9. Cultivation of coca bush in Bolivia, Colombia and Peru, 2009 to 2016 (in hectares)⁵⁴²



Credit: Marie Nougier, IDPC

Box 15 Colombia's peace process: Great hopes, significant challenges

Colombia's internal armed conflict dates back to the 1960s, but it was not until the 1980s that coca cultivation started to expand in areas controlled by the FARC (Fuerzas Armadas Revolucionarias de Colombia) and paramilitary groups started engaging in the booming cocaine market. In the past four decades, Colombia has implemented forced eradication strategies to combat illegal drug supply, including aerial spraying, manual eradication, criminalisation of growers, destruction of processing 'laboratories' and interdiction. This strategy has had serious financial, environmental, social and human rights implications,⁵⁴³ among them the internal displacement of millions of people as a result of the conflict with the FARC and violent clashes with the military in coca cultivation areas.⁵⁴⁴

In 2012, the Colombian government and the FARC began peace talks, with an agenda item on 'Solution to the illicit drug problem'. Chapter 4 of the 2016 Peace Agreement, dedicated to drug issues, paved the way to a new approach towards illegal drug production, with due regard to rural development (chapter 1). Under the National Comprehensive Substitution Programme, farmers involved in illegal crop cultivation are encouraged to sign agreements with the state to voluntarily eradicate coca crops. In exchange, they receive a state subsidy, and the government committed to improving land ownership, access to public goods, markets and infrastructure and access to credit.⁵⁴⁵ 124,000 families across Colombia have expressed willingness to benefit from the Programme – representing approximately 100,000 hectares of coca. Individual agreements were signed with 77,000 families. The UNODC supports this initiative by monitoring compliance with the required 'voluntary' self-eradication.⁵⁴⁶ As of July 2018, the UNODC confirmed the self-eradication of 18,000 hectares, with another 10,000 hectares still under verification.

The pilot for this 'voluntary substitution' programme started in Briceño, Antioquia where, in an effort to generate trust, the government and the FARC committed to work with the farming community of 11 villages in the municipality to foster economic change and reduce their dependence on coca. Although the peace

agreement itself included references to coca-growing communities' right to participate in decision-making processes in order to facilitate the voluntary and peaceful destruction of coca plants, those communities were in fact given no space at all to negotiate the terms of the contracts and were forced to sign up under the threat of forced eradication.⁵⁴⁷

The joint substitution effort, however, is faced with several challenges, not least the serious setback created by the referendum vote against the original Peace Agreement in October 2016, the fact that the government and the FARC only released implementation protocols in February 2017, and the overall lack of coordination between state institutions. In addition, bureaucratic processes created delays in payments to participating families, while agricultural technical assistance, access to land and lack of basic infrastructure are lagging behind.⁵⁴⁸ In parallel, the bill providing differential criminal treatment for coca farmers has not yet been passed, making them vulnerable to arrest and incarceration. Moreover, although financial subsidies are offered to families in exchange for voluntary eradication, the programme lacks a comprehensive, long-term development strategy that is able to deliver alternative crop cultivation and income generation.

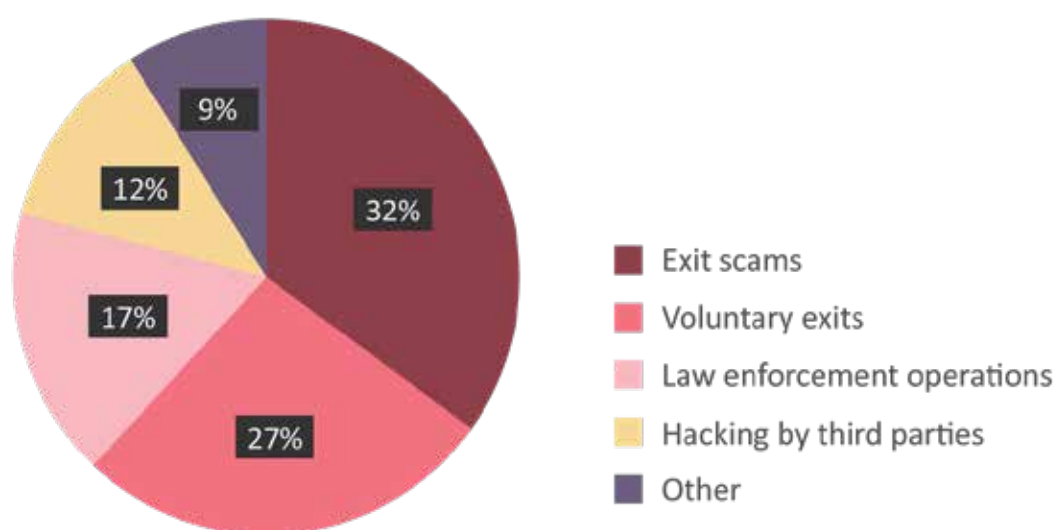
Cases of violence also continue to be reported in affected areas – with the UN estimating that 106 community leaders were killed in 2017 alone.⁵⁴⁹ Finally, Colombia is facing growing international pressure due to the recent surge in coca cultivation, making the country the world leader in coca cultivation. The recent election of President Duque, who openly pronounced himself in favour of forced crop eradication, presents yet another key challenge for the years ahead.⁵⁵⁰ It is equally worrying that, in its 2017 'Colombia coca cultivation survey', the UNODC seems to encourage this approach, recommending that 'Forced eradication should be implemented on coca lots where growers did not sign agreements to achieve continuous, coca-free territories'.⁵⁵¹ These many issues highlight the urgency of guaranteeing more security, human rights protection and sustainable development in the implementation of the Peace Process.

Box 16 Crypto-drug market operations

Crypto-drug markets have been in operation since 2010, but have gained importance with the Silk Road website in February 2011. Dark net markets usually remain active for just a few months up to a few years, and so the landscape changes rapidly, making it all the more difficult for drug law enforcement to target these online

markets. Most closures, however, do not result from law enforcement action (only 17% of crypto-drug market closures), but are generally the result of 'exit scams' (where operators suddenly close down the site and steal the money), voluntary exits and hacking by third parties⁵⁵² (see Figure 10).

Figure 10. Causes of closure of crypto-drug markets⁵⁵³



Since 2009, the use of the internet to facilitate transnational illegal drug transactions has become a phenomenon of growing significance. In the past decade responses to crypto-drug markets have been undertaken either unilaterally or through pre-existing strategic and security cooperation alliances, often on an ad-hoc basis, and in a vacuum left by the absence of clear international policy. According to the UNODC, 42% of member states have a system in place to monitor the sale of illegal drugs over the internet – with no increase since 2009.⁵⁵⁴ Policy making in the area has been constrained by an inadequate technological understanding of the phenomenon, and without the required common legal frameworks necessary to adequately address the trans-jurisdictional nature of the issue.

A 2016 study⁵⁵⁵ noted that crypto-drug markets continue to account for a relatively small percentage of drug sales globally, with all internet-facilitated transactions totalling around 1% of the total market, but that percentage represented an increase of 50% in the period 2013-2015. Since the first mention of dark net markets in the UNODC's World Drug

Report 2014,⁵⁵⁶ the UNODC has consistently – and with an increasing sense of alarm – described the issue as 'growing',⁵⁵⁷ and recognised the need for more research, money, and innovative thinking.⁵⁵⁸ In practical terms, although the usage of these markets remains dominated by the Global North,⁵⁵⁹ their international reach has extended in recent years with the appearance of Chinese vendors of NPS, precursors, fentanyl and fentanyl analogues. As such, crypto-drug markets are growing in several areas – in relation to traditional markets, in political significance, and in global reach. In 2017, UNODC's Executive Director also conceded that drugs bought and sold online frequently utilise postal services for distribution,⁵⁶⁰ highlighting the lack of progress made by the international community towards the 2009 goal of curbing postal trafficking.

Many state-level law enforcement and criminal justice systems remain ill-equipped to deal with the issue of crypto-drug markets.⁵⁶¹ Although there has been some international law enforcement cooperation on the issue – most notably between US federal agencies, Europol, and state-level

enforcement – cooperation has occurred despite muddled international policy direction. States taking action have done so in response to pressing and immediate domestic law enforcement or public health challenges, rather than as part of any coherent policy landscape.⁵⁶² Other states – such as the UK and Germany – have also taken action in response to requests for security cooperation from long-standing allies. More recently, individual member states have worked within pre-existing alliances to coordinate several high-profile market interventions. In general, US agencies continue to lead on the issue, as they have since the closure of the original Silk Road website in October 2013. Of European states, the Netherlands has been notably proactive in the area, playing a key role alongside Europol in *Operation Bayonet* in 2017.⁵⁶³

In the absence of cohesive national and international policy in the area, law enforcement agencies have continued the approach of shutting down markets, apprehending administrators, and seizing server assets in strategies reminiscent of the traditional offline drug law enforcement operations. So-called ‘takedown’ operations seek to exploit either of two key structural weaknesses: the markets’ centralised authority (by apprehending the human administrators of the sites), and/or the physically-centralised servers themselves. In each case, the takedowns result in the market sites going offline, but the subsequent effect on vendors and buyers is less clear. Recent research suggests that takedown strategies may play a significant role in provoking technological innovation,⁵⁶⁴ and the UNODC acknowledges that more research is required to better understand the effects of ‘hard’⁵⁶⁵ interventions.⁵⁶⁶

Indeed, it is not yet clear whether closure undermines trust in – or the will to use – crypto-drug markets among people who use drugs. In 2018, only 15% of respondents to the Global Drug Survey said they felt closures discouraged their use of online markets, and only 9% had stopped altogether, with more than 50% reporting that takedown had no effect on their usage patterns.⁵⁶⁷ Further, there is evidence of market migration, fragmentation, and online ‘turf wars’ similar to patterns observed in traditional markets, as surviving markets vie for market share following takedowns. This has led Europol to conclude that ‘law enforcement interventions in the form of darknet market take-downs disrupt darknet markets, although the overall ecosystem appears to be fairly resilient with new markets quickly becoming established’; and vendors and customers migrating to the latest trading platform to continue their operations.⁵⁶⁸ Acknowledging this phenomenon,

Operation Bayonet represented a somewhat evolved approach, with Europol and the US Department of Justice working together to quietly seize and operate AlphaBay as an intelligence ‘honeypot’,⁵⁶⁹ in advance of taking down Hansa Market. Despite the new approach, there is evidence that crypto-drug markets are already evolving toward decentralised and distributed models.⁵⁷⁰

Nevertheless, there is also evidence demonstrating the potential of such online platforms to reduce health harms for people who use drugs. Available research has shown that anonymised user forums and online chat rooms facilitate peer-based reviews and feedback about the quality of drug purchases, reliability of sellers, the purity and effects of certain products, representing a novel form of peer-based harm reduction, as well as ‘an entry point for drug support services’.⁵⁷¹

Today, crypto-drug markets continue to operate as an efficient and growing means to transact cannabis, cocaine, and prescription opioids.⁵⁷² They also facilitate the ‘marketing and distribution of, and trafficking in, psychotropic substances, including synthetic drugs’⁵⁷³ as well as precursors. Furthermore, crypto-currencies provide a means to launder money associated with the drug trade (see [Section 2.2.4](#) below). In short, the continued proliferation of crypto-drug markets speaks directly to many of the goals of the 2009 Political Declaration, and shows lack of progress for each.

2.2.3 Tackling money-laundering

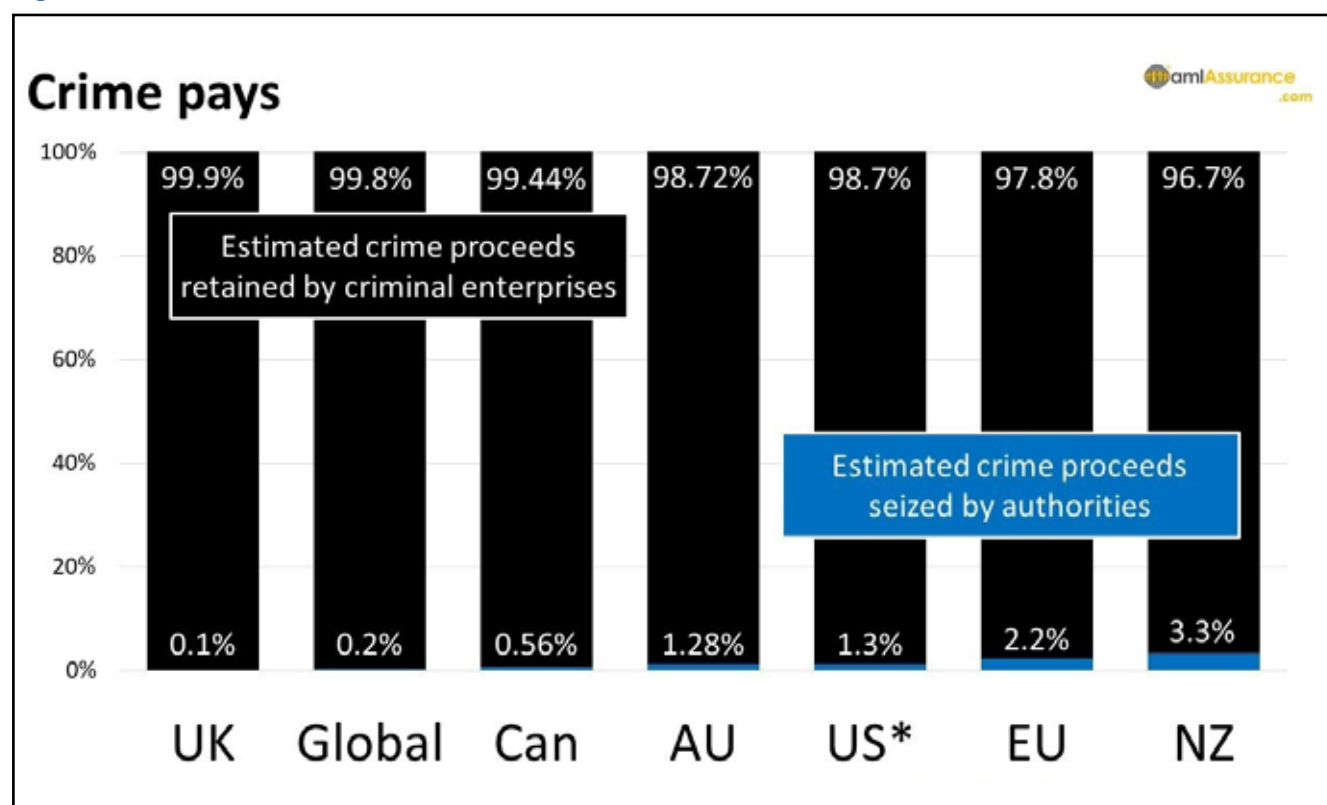
2009 Political Declaration and Plan of Action

Action 51(a): ‘Establishing new or strengthening existing domestic legislative frameworks to criminalize the laundering of money derived from drug trafficking, precursor diversion and other serious crimes of a transnational nature in order to provide for the prevention, detection, investigation and prosecution of money laundering’

Action 51(d): ‘Promoting effective cooperation in strategies for countering money-laundering and in money-laundering cases’

International provisions against money-laundering were first included in the 1988 United Nations Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances as a strategy against drug trafficking by criminal organisations. The implementation of concrete measures was entrusted

Figure 11. Interdiction rates and criminal proceeds retained by criminal enterprises in selected high-income countries⁵⁷⁴



Credit: 'Uncomfortable truths? ML=BS and AML=BS?'; Journal of Financial Crime

by the G7 to the Paris-based Financial Action Task Force (FATF) in 1989, which became the global anti-money-laundering standard-setter.⁵⁷⁵ A number of regional task forces modelled on the FATF were established in the 1990s and the 2000s – such as the Asia/Pacific Group on Money-laundering,⁵⁷⁶ the Financial Action Task Force for Latin America,⁵⁷⁷ the Inter-Governmental Action Group Against Money Laundering in West Africa,⁵⁷⁸ among others.

Since 2009, several instruments have been adopted to consolidate the work of the FATF. These include the adoption, in 2012, of the 'International standards on combating money-laundering and the financing of terrorism & proliferation – the FATF recommendations', which aim to strengthen international safeguards and protect the integrity of financial systems by providing governments with stronger tools to take action against financial crime.⁵⁷⁹ A year later, member states adopted the 'Methodology for Assessing Compliance with the FAFT Recommendations and the Effectiveness of [Anti-Money-laundering/Countering the Financing of Terrorism] Systems', to help determine whether a country is sufficiently compliant with the 2012 standards, and whether their systems work effectively – with rounds of evaluation taking place regularly.⁵⁸⁰

The UNODC has its own programmes to tackle money-laundering, in particular the 'Global pro-

gramme against money-laundering, proceeds of crime and the financing of terrorism' which encourages member states to develop policies to counter money-laundering and the financing of terrorism, monitors and analyses related problems, raises awareness and coordinates initiatives carried out by the UN and other international organisations.⁵⁸¹ Through this programme, the UNODC has cooperated with a range of international and regional organisations, including with the World Bank, the International Monetary Fund, the Organisation for Security and Cooperation in Europe, Interpol and others.⁵⁸² In April 2009, just a month after the adoption of the 2009 Political Declaration, the UNODC published its 'Model provisions on money-laundering, terrorist financing, preventive measures and proceeds of crime',⁵⁸³ which are meant to be a 'starting point for State authorities as they evaluate the measures that should be incorporated into domestic law in order to prevent, detect, and effectively sanction money-laundering, the financing of terrorism and the proceeds of crime'.⁵⁸⁴ The World Bank also provides technical assistance to member states in developing effective laws, regulations and institutional framework, assessing the impact of money-laundering, training the financial sector supervisors, investigators, prosecutors, judges, designing effective asset disclosure

systems for public officials, conducting national risk assessments.

Evaluation of anti-money-laundering efforts by the UNODC have mainly focused on 'process' or 'activity' indicators. The data available through ARQ responses show that despite these global efforts, little progress has been recorded at national level in the past decade. In 2018, the UNODC reported a slight increase, from 37% in 2010 to 40% in 2016, in the percentage of states having legislation providing for the conclusion of bilateral or multilateral asset-sharing agreements. However, it recorded a slight fall between 2010 and 2016 in the percentage of states having measures in place to manage seized assets, for banks and other financial institutions to identify customers and verify their information to trace proceeds of crime, and to detect and monitor the cross-border transport of cash. There was also a slight decrease in the proportion of states in which it is mandatory to report suspicious transactions.⁵⁸⁵ Despite the recorded slight fall, all these percentages remain relatively high, at around 70% of reporting states – although it should be noted that only about 10% or less of member states in Sub-Saharan Africa, Oceania and the Caribbean provided consistent data on this issue (see [Box 1](#)).

When one looks into the impacts that these processes have yielded on the scale of money-laundering, the results have been minimal. Despite an expansion in global tools and collaboration at regional and international level to tackle money-laundering, the illegal drug trade remains the second largest source of income of transnational organised crime groups,⁵⁸⁶ who continue to launder money with impunity. Indeed, as discussed [above](#), UNODC research concluded that less than 1% of the total amounts laundered were seized.⁵⁸⁷ In 2016, Europol's Asset Recovery Unit frankly admitted that in Europe from 2010 to 2014, only 2.2% of the estimated proceeds of crime were provisionally seized or frozen, and ultimately just 1.1% of the criminal profits were finally confiscated at EU level.⁵⁸⁸ A 1.1% interception rate means that '98.9 percent of estimated criminal profits are not confiscated and remain at the disposal of criminals',⁵⁸⁹ that is, in addition to the accumulated criminal wealth from previous years. The 2013 HSBC money-laundering scandal⁵⁹⁰ and the Panama Papers in 2016⁵⁹¹ are merely two examples of the scale of the issue.

Figure 11 highlights the interdiction rates and criminal proceeds retained by criminal enterprises in high-income countries. Tackling money-laundering in lower-income countries, with fewer resources, may prove to be even more challenging. New

technologies present additional challenges to the current anti-money-laundering framework, with growing volumes of transactions and large data sets requiring computational analysis to reveal patterns, trends and associations. The growing demand for online services and related internet payment systems also pose challenges with borderless virtual environments requiring an adaptation of current strategies.⁵⁹² In its 2018 World Drug Report, the UNODC concluded that drug-related money-laundering affected the economy in a number of ways, including by inflating property prices, distorting export figures, as well as by exacerbating unfair competition, the gap in wealth distribution and corruption, while negatively affecting foreign investment in developing countries.⁵⁹³

This is not to say that the anti-money-laundering regime has entirely failed. Since 2000, most countries have adopted more legislation to tackle money-laundering and extended the scope of their surveillance activities. There have also been more convictions for money-laundering, and countries are better equipped to cooperate against serious crimes and to seize proceeds. However, a thorough cost-benefit analysis remains to be undertaken on anti-money-laundering efforts, both globally and nationally.⁵⁹⁴ Furthermore, the anti-money-laundering regime may also generate harms – efforts to control money-laundering may lead banks to cut down overseas remittances to 'the most vulnerable populations in the poorest countries'.⁵⁹⁵ The failure to control illegal money flows also extends to the failure to counter tax evasion, tax avoidance and trade mispricing, which is eroding the tax base for development. Finally, it is worth noting that the anti-money-laundering regime – which requires tighter government controls over the banking sector – was developed at a time when the world was in a process of complete deregulation of financial markets. It is unlikely that any significant improvement in tackling money-laundering will materialise until there is political will to better control the financial sector.⁵⁹⁶

2.3 Advancing development

The third key priority of the UN, as established in its founding Charter, was to ‘achieve international co-operation in solving international problems of an economic, social, cultural, or humanitarian character’,⁵⁹⁷ and improving people’s well-being worldwide through a comprehensive development approach that ‘promotes prosperity and economic opportunity, greater social well-being, and protection of the environment.’⁵⁹⁸ This approach was first reflected in the Millennium Development Goals (2000-2015),⁵⁹⁹ and has since then been consolidated in the 2030 Sustainable Development Agenda.⁶⁰⁰

2.3.1 Analysing factors leading to illegal cultivation

2009 Political Declaration and Plan of Action

Action 43(b): ‘Conduct research to assess the factors leading to the illicit cultivation of drug crops used for the production of narcotic drugs and psychotropic substances’

There are many factors leading to the cultivation of crops; primary among them is insecurity, armed conflict, poverty, marginalisation and lack of opportunities in the licit market. Another is cultivation

for personal recreational use, and yet another is traditional usage. While cultivation for recreational and traditional use have so far not been adequately discussed at global level, progress has been made in identifying the developmental factors linked to illegal crop cultivation. For instance, the UNGASS Outcome Document requests member states to address the factors related to illegal crop cultivation ‘by implementing comprehensive strategies aimed at alleviating poverty...and by promoting sustainable development aimed at enhancing the welfare of the affected and vulnerable population through licit alternatives.’⁶⁰¹ The UNODC, which had traditionally mostly focused on assessing the impact of alternative development programmes through reductions in hectares of crops cultivated, is also taking steps to broaden its traditional ‘Crop Monitoring’ surveys to include socio-economic issues. An example of this new approach is the 2016 Afghanistan opium survey, in which the UNODC documented the links between illegal crop cultivation and various SDGs⁶⁰² (see Figure 12).

In its contribution to the 2016 UNGASS, the United Nations Development Programme was also instrumental in documenting and analysing the links between poverty and engagement in the illegal drug trade, in particular,⁶⁰³ and is now engaged in a very important exercise being carried out with the University of Essex to elaborate *International Human*

Assessing progress on Development

Alternative development

In the 1960s

Thailand

initiated efforts to address the underlying causes of opium cultivation, leading to:

↑ Alternative sources of income (before eradication)

↑ Environmental protection

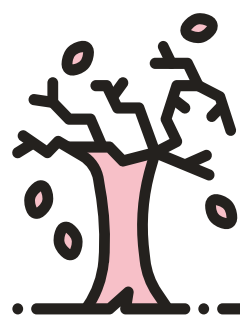
↑ Access to healthcare and public services (education, electricity, clean water)

↑ Small-scale businesses

Alternative development

requires addressing the socio-economic vulnerabilities that push people into the illicit market

Sequencing



Adequate sequencing requires that no eradication occurs before there are sufficiently developed alternative sources of income.

The importance of **Proper sequencing** tends to be ignored and **alternative development** is often subordinated to **crop eradication**

Regulating coca production

Bolivia's community coca control

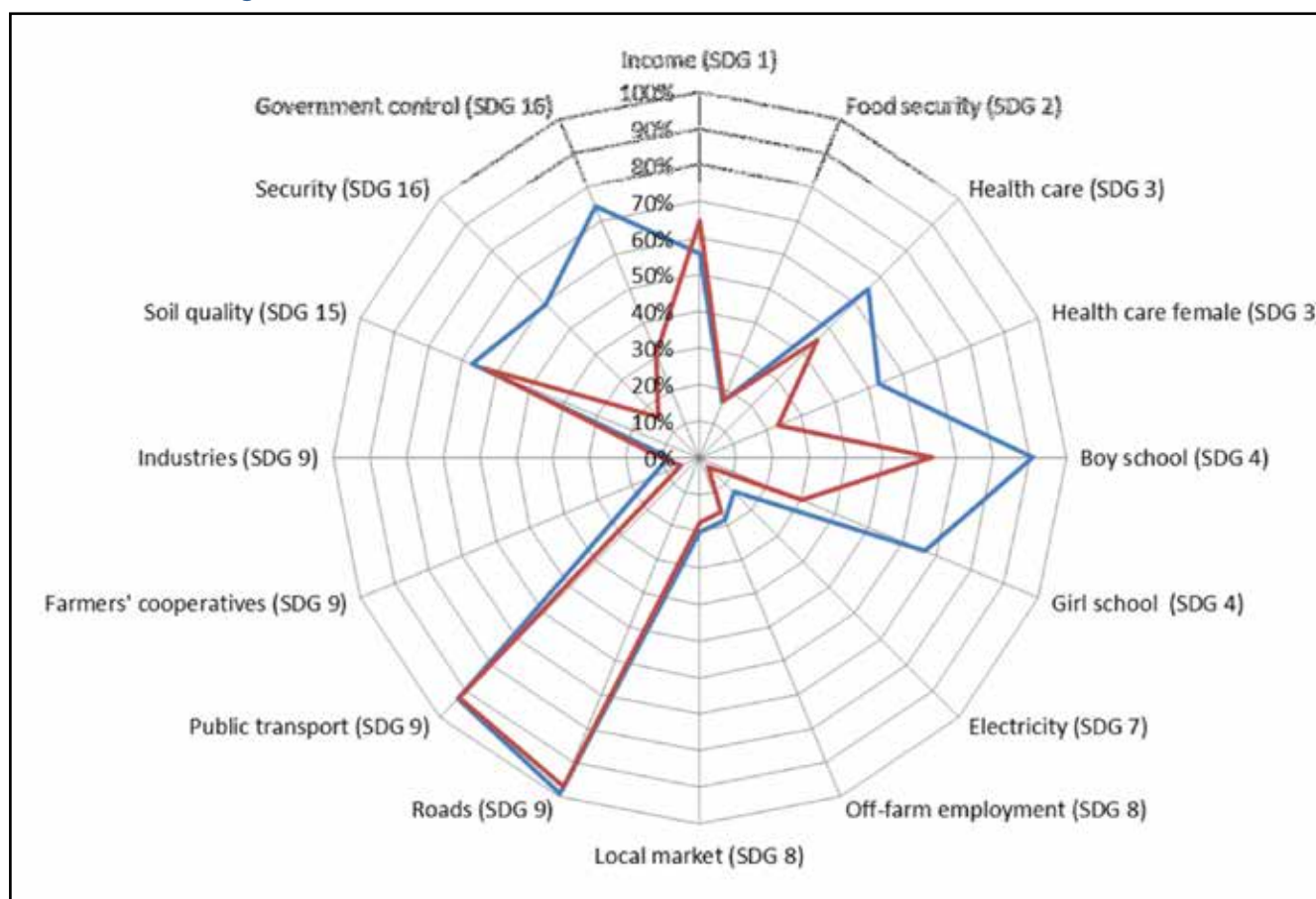
Regulated legal cultivation
Registered growers can grow on a limited extension of land.

Investment in development
Non-conditional support in coca-growing areas.

Enforced regularly
By both local growers unions and state agencies.

Constitutional protection
The Constitution asserts the plant's cultural significance.

Figure 12. Percentage of villages with and without opium poppy cultivation progressing towards selected SDGs in Afghanistan, 2016⁶⁰⁴



Rights Guidelines on Drug Control, including sections devoted to cultivation, rural development and indigenous uses of psychoactive plants. Similarly, several NGOs have conducted valuable research to better understand the factors leading to illegal crop cultivation and engagement in other aspects of the illegal drug trade.⁶⁰⁵

At national level, in 2018 the UNODC reported that only 'some member states' had conducted studies evaluating the impact of their alternative development programmes, while 'others' (not quantified) used human development indicators to review impact.⁶⁰⁶ Although limited, this is a recognition of the need to address the developmental factors pushing many vulnerable people to engage in illegal drug activities. Furthermore, since 2009, several new initiatives

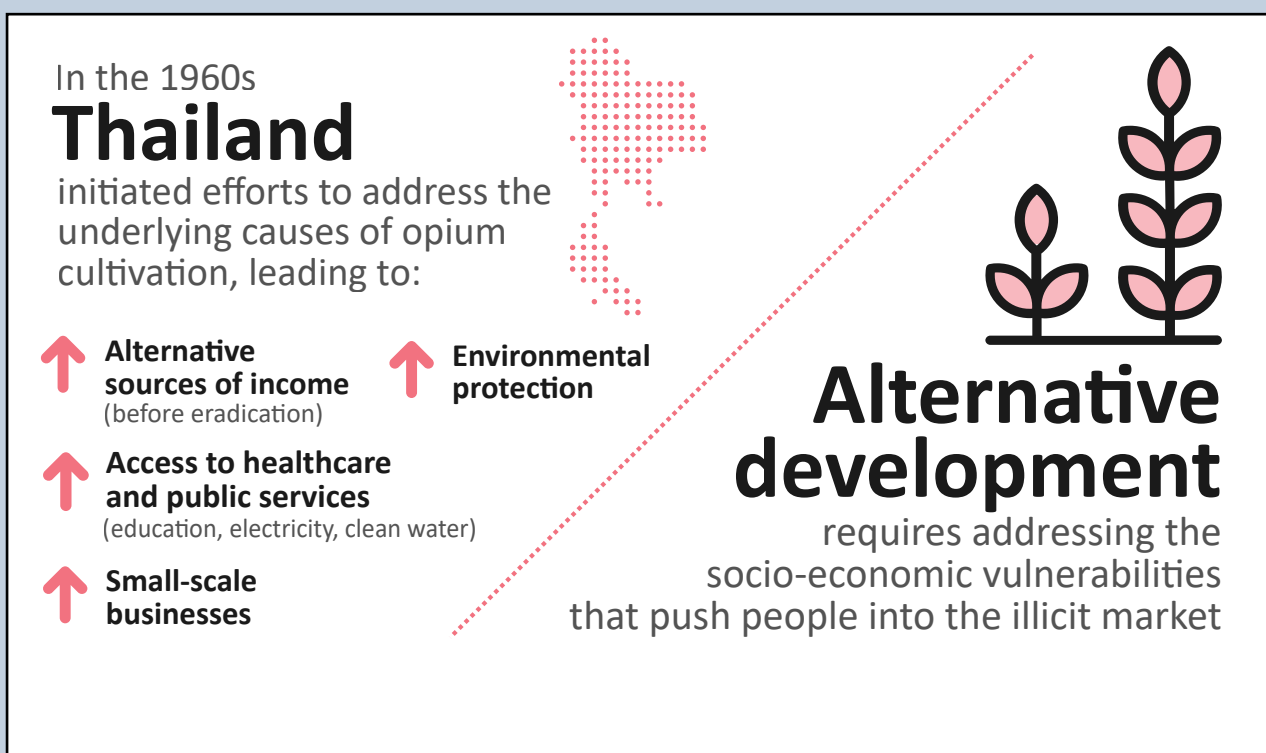
have led to the production of detailed research⁶⁰⁷ and tools⁶⁰⁸ and have facilitated constructive dialogue among the UN, member states, civil society and academia, to better understand the development factors contributing to engagement in illegal cultivation and trafficking. This includes the 'Global Partnership on Drug Policies and Development' (GPDPP) programme led by the German development agency GIZ,⁶⁰⁹ and the Cooperation Programme between Latin America, the Caribbean and the European Union on Drug Policies (COPOLAD) project.⁶¹⁰ At the same time, the need to evaluate alternative development projects by utilising human development indicators has been an issue of debate in UN expert meetings on alternative development for nearly two decades, yet remains the exception rather than the rule.

Box 17 Adopting a development approach to illegal cultivation: The case of Thailand

In the 1960s, Thailand was one of the main producers of opium. However, instead of prioritising forced crop eradication, the government decided to undertake major long-term development efforts to address the underlying causes of involvement in opium cultivation. The strategy focused on providing agricultural alternatives, improving access to healthcare and education and developing basic infrastructure such as roads, electricity and clean water supplies. The alternative livelihoods programme was incorporated in the broader local and national development strategy and consisted in a bottom-up approach, driven by community engagement and strong partnerships with community leaders. The programme was also adequately sequenced, ensuring that opium poppy fields would not be eradicated until basic services and alternative livelihoods were in place.⁶¹¹

A 2018 study by the Mae Fah Luang Foundation found that this approach had contributed to reducing poverty levels among subsistence farm-

ers who were able to turn to alternative sources of income before opium poppy was eradicated, increasing household incomes and facilitating the development of small-scale businesses. The regions in which the programme was implemented now benefit from more diverse economic activities, including the cultivation of crops like tea, Inca, peanut and bamboo, and increased tourism thanks to improved infrastructure. Access to healthcare (including drug dependence treatment), education, electricity and clean water was also improved, and environment protection became an essential component of the approach through sustainable land distribution, reforestation initiatives and environmental education incorporated in school curriculums.⁶¹² However, it is also important to point out that poppy cultivation migrated to other countries, mainly to neighbouring Myanmar, and that the Thai drug market shifted from opium/heroin to methamphetamines being the primary drug of concern.



2.3.2 Promoting sustainable development in cultivation and trafficking areas

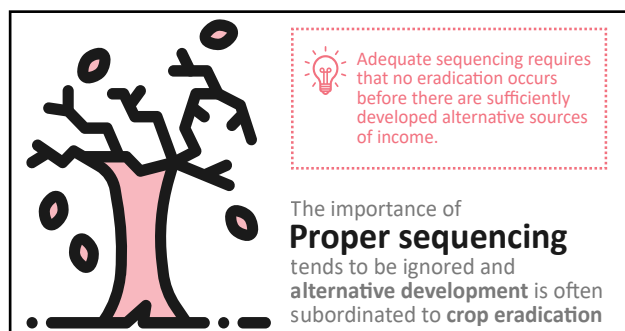
2009 Political Declaration and Plan of Action

Action 45(c): ‘Establish, where possible, sustainable alternative development programmes, in particular in drug-producing regions, including those with high levels of poverty, as they are more vulnerable to exploitation by traffickers and more likely to be affected by the illicit cultivation of drug crops and the illicit production of and trafficking in narcotic drugs and psychotropic substances’

Action 45(d): ‘Consider, where appropriate, including in their national development strategies, integrated and sustainable alternative development programmes, recognizing that poverty and vulnerability are some of the factors behind illicit drug crop cultivation and that poverty eradication is a principal objective of the Millennium Development Goals; and request development organizations and international financial institutions to ensure that alternative development strategies, including, when appropriate, preventive alternative development programmes, are incorporated into poverty reduction strategy papers and country assistance strategies for States affected by the illicit cultivation of crops used for the production of narcotic drugs and psychotropic substances’

Action 47(f): ‘Ensure the proper and coordinated sequencing of development interventions when designing alternative development programmes; and, in this connection, the issues of the establishment of agreements and viable partnerships with small producers, favourable climatic conditions, strong political support and adequate market access should be taken into account’

In 2009, UN member states had recognised the need to address the socio-economic vulnerabilities pushing people to engage in illegal drug cultivation and trafficking via sustainable development strategies, with mention made to the Millennium Development Goals. Since 2009, most countries affected by illegal crop cultivation have adopted some form of alternative development programme, generally alongside eradication campaigns. These include Afghanistan, Bolivia, Colombia, Ecuador, Indonesia, Lao PDR, Morocco, Myanmar, Peru, the Philippines and Thailand.⁶¹³ However, few have embedded



Credit: Juan Fernandez Ochoa, IDPC

these programmes in a comprehensive, long-term sustainable development strategy.

In this regard, ‘proper and coordinated sequencing of development interventions’ is perhaps one of the most problematic issues related to alternative development. Proper sequencing means that no eradication should take place until there are sufficiently developed alternatives in place to ensure subsistence farmers’ survival.⁶¹⁴ In theory, most alternative development programmes implemented since 2009 have included the concept of adequate sequencing. However, in practice only Bolivia and Thailand seem to have respected this core component of an effective sustainable development approach. Others have merely implemented alternative development programmes as a complementary aspect of, or to justify, crop eradication, rather than as the primary means of creating the conditions that would improve people’s livelihoods and reduce their dependence on illegal crop cultivation.⁶¹⁵ The cases of Colombia (see [Box 12](#)) and Peru are particularly illustrative of these concerns. In Thailand, efforts were made to implement a long-term development strategy for about 15 years before opium poppy started being eradicated, in close consultation with the local communities (see [Box 17](#)). In Bolivia, the government’s approach has focused on ensuring that farmers could grow a sufficient amount of coca for subsistence purposes, facilitating access to a national legal market for coca products, improving access to safe water, education and promoting additional sources of income.⁶¹⁶

With regards to drug trafficking, it was only recently that the UN started recognising the complex vulnerabilities of those engaging in drug trafficking, with most debates revolving around women. The conversation made a significant step forward at the UNGASS, and with the adoption of Resolution 59/5 ‘Mainstreaming a gender perspective in drug-related policies and programmes’ which ‘Urges Member States to implement broad-based programmes aimed at preventing women and girls from being used as couriers for trafficking in drugs’.⁶¹⁷ The UNGASS Outcome Document also includes various

Box 18 Addressing the vulnerabilities faced by women: The case of Costa Rica

In 2017, Costa Rica had the fifth highest incarceration rate in Latin America, at 374 per 100,000 inhabitants. Two in ten prisoners are currently in prison for drug offences – reaching a ratio of six in ten among female prisoners. The most common offences for which people are incarcerated include smuggling drugs in prisons, micro-trafficking, drug transportation and small-scale selling (drug possession for personal use is not criminalised in Costa Rica). Women incarcerated for drug offences are usually first time non-violent offenders, single mothers of several children, with limited formal education or employment possibilities. Their mass incarceration has had a devastating impact on women and their families and has led to serious prison overcrowding and poor prison conditions. In an effort to decongest the criminal justice system and guarantee basic rights for prisoners, the Costa Rican government has carried out a series of legislative and political reforms.

Starting in 2013, Law 9161 (known as ‘77bis’) was approved and reduced the prison sentence for women accused of smuggling drugs in prison (a reduction from 8-20 years to 3-8 years), guaranteeing more proportionality and a gender perspective in Costa Rica’s drug legislation. The law opened up the possibility of alternatives to incarceration for women in situations of vulnerability accused of this specific drug offence.⁶¹⁸ The approval of the law directly benefited a quarter of women incarcerated for drug offences with the immediate release of more than 120 women.⁶¹⁹ The mass

release of women from prison led to the creation of an inter-institutional network for the social re-integration of women in conflict with the law. This network includes eight public institutions working in the areas of health, gender, family, employment, the judiciary, prisons and drug control. The active coordination of the Ministry of Women for the provision of a wide range of services and direct support to formerly incarcerated women has been instrumental to the network’s success.⁶²⁰

The most recent reform was the approval of Law 9361 in early 2017, which reduces the time for which a criminal record is kept, according to the offence committed and the penalty imposed. This was in recognition of the difficulty faced by formerly incarcerated individuals to find employment after their release, increasing their vulnerability to poverty and re-engagement in criminal activities. The law also allows the immediate elimination of the criminal record for people found in situation of vulnerability. Before the reform, criminal records were kept in the judicial registrar for 10 years, without distinction between serious or minor crimes.⁶²¹ Interestingly, this reform initiative was initially going to target those who had committed drug offences and was then expanded to cover more offences. It has nonetheless had a major impact for drug offenders. The Costa Rican experience is therefore an excellent example of how to address the situation of poverty, marginalisation and exclusion faced by people engaged in criminal activities for subsistence purposes.



Buen Pastor prison for women in San Jose, Costa Rica

Credit: Jessamine Barley-Matthews, WOLA

Box 19 Resolutions on alternative development adopted between 2009 and 2018

CND resolution 61/6. Promoting the implementation of the United Nations Guiding Principles on Alternative Development and related commitments on alternative development and regional, interregional and international cooperation on development-oriented, balanced drug control policy addressing socioeconomic issues (2018)

CND resolution 58/4. Promoting the implementation of the United Nations Guiding Principles on Alternative Development (2015)

CND resolution 57/1. Promoting the implementation of the United Nations Guiding Principles on Alternative Development and proposal to organize an international seminar/workshop on the implementation of the Guiding Principles (2014)

CND resolution 56/15. Follow-up to the Plan of Action on International Cooperation towards an Integrated and Balanced Strategy to Counter the World Drug Problem with respect to the development of strategies on voluntary marketing tools for products stemming from alternative development, including preventive alternative development (2013)

CND resolution 55/8. Follow-up to the Plan of Action on International Cooperation towards an Integrated and Balanced Strategy to Counter the World Drug Problem with respect to the development of strategies on special marketing regimes for alternative development, including preventive alternative development (2012)

CND resolution 55/4. Follow-up on the proposal to organize an international workshop and conference on alternative development (2012)

CND resolution 54/4. Follow-up on the proposal to organize an international workshop and conference on alternative development (2011)

CND resolution 53/6. Follow-up to the promotion of best practices and lessons learned for the sustainability and integrality of alternative development programmes and the proposal to organize an international workshop and conference on alternative development (2010)

CND resolution 52/6. Promoting best practices and lessons learned for the sustainability and integrality of alternative development programmes (2009)

key operational recommendations urging member states to take into account the specific vulnerabilities faced by women engaging in the illegal drug trade.⁶²²

Nationally, only a few UN member states have translated these recommendations into practice. In 2012, the UK revised its sentencing guidelines to take into account the role of women in the overall drug trafficking chain during trial, with the recognition of various situations of vulnerability as mitigating factors – although the failure to review drug legislations has meant that these new guidelines only had a limited impact.⁶²³ In 2014, Ecuador adopted a new criminal code to ensure more proportionate sentencing for drug offenders, in particular micro-traffickers, in recognition that those at the lowest level in the drug trafficking chain were generally involved in drug activities because of socio-economic issues. However, the legislation was revised in 2015 which severely limited the positive impacts of the new policy on reducing prison overcrowding.⁶²⁴ Costa Rica is by far the country which has made most progress on this issue (see [Box 18](#)).

2.3.3 Support and cooperation for alternative development

2009 Political Declaration and Plan of Action

Action 43(d): ‘Ensure that States with the necessary expertise, the United Nations Office on Drugs and Crime and other relevant United Nations organizations assist affected States in designing and improving systems to monitor and assess the qualitative and quantitative impact of alternative development and drug crop eradication programmes with respect to the sustainability of illicit crop reduction and socio-economic development; such assessment should include the use of human development indicators that reflect the Millennium Development Goals’

The UNODC is currently supporting alternative development programmes in various countries, including Afghanistan, Bolivia, Colombia, Lao PDR, Myanmar and Peru.⁶²⁵ However, donors’ financial support for alternative development initiatives has

been steadily reduced since 2009. The 2015 World Drug Report included a dedicated section on alternative development, concluding that: 'Despite the amount of attention given to alternative development at the international level, there is a disconnect between international rhetoric and funding.'⁶²⁶ Despite the level of visibility given to alternative development in the CND (see [Box 19](#)) and the UN General Assembly,⁶²⁷ the report continues, 'the funding for it has decreased considerably in the last few years'. In fact, 'overall gross disbursements of alternative development funds from OECD countries have declined by 71 per cent since the adoption of the Political Declaration and Plan of Action on International Cooperation towards an Integrated and Balanced Strategy to Counter the World Drug Problem.'⁶²⁸

As noted above, GPDPD and COPOLAD have taken the lead in facilitating country visits in areas benefiting from alternative development programmes, providing technical support, providing guidance for assessing the impacts of different alternative development strategies on broader human development indicators and aligning alternative development efforts with the SDGs.

2.3.4 Ensuring collaboration with local communities in illegal crop cultivation areas

2009 Political Declaration and Plan of Action

Action 45(f): 'Ensure that the design and implementation of alternative development programmes, including, when appropriate, a preventive approach, involve all stakeholders, take into account the specific characteristics of the target area and incorporate grass-roots communities in project formulation, implementation and monitoring'

Action 47(b): 'Develop alternative development programmes and eradication measures while fully respecting relevant international instruments, including human rights instruments, and, when designing alternative development interventions, taking into consideration the cultural and social traditions of participating communities'

Action 47(d): 'Ensure that the implementation of alternative development and preventive alternative development, as appropriate, enhances synergy and trust among the national Government, local administrations and communities in building local ownership'



Credit: OCCDI Global

The need to involve affected communities in the design, implementation and monitoring of alternative development programmes is recognised in three actions. Community involvement in these programmes is critical to ensure that they are realistic and adapted to the local terrain, market access and know-how of affected communities. This key principle was recognised in the UN General Assembly Resolution 68/196 'United Nations guiding principles on alternative development' and in the UNGASS Outcome Document.⁶²⁹ In its 2018 report on UNGASS implementation, the OHCHR also recognised that 'In terms of the design of alternative development programmes, the participation of those affected, including women, minorities and indigenous peoples, should be essential.'⁶³⁰

On the ground, however, and with some notable exceptions, meaningful community participation in alternative development programmes is sorely lacking. For example, while the Colombian Peace Agreement recognises that poverty and conflict are at the root of coca cultivation in that country and calls for significant community involvement in rural development efforts,⁶³¹ in reality community participation was very limited. Despite being called to participate in many meetings, they were not given a significant role in negotiating the terms of crop substitution contracts, were forced to sign up for 'voluntary' coca eradication under the threat of forced eradication and had little opportunity for meaningful input into development plans, which lag way behind in implementation (see [Box 15](#)). Thailand and Bolivia seem to have yielded better results. In Bolivia, a social control system enables farmers to cultivate a certain amount of crops, while the community is responsible for ensuring that households do not produce more than the quantity authorised (see [Box 18](#)).⁶³² In Thailand, the government's long-term development strategy in opium cultivation areas has promoted a bottom-up approach aiming to identify the needs and problems of affected communities, building partnerships with local communities and community leaders, and incorporating local know-how in all aspects of the programme (see [Box 20](#)).⁶³³

Box 20 Bolivia's community coca control

Andean indigenous communities have used the coca leaf in cultural rituals, social and economic interactions, and medicinal uses for centuries.⁶³⁴

From 1980s until the early 2000s, Bolivia's drug control strategy fuelled forced coca eradication leading to human rights violations and exacerbating the poverty of affected farmers. From 2006 onwards, Bolivia has shifted its strategy to expand and protect the rights of indigenous coca growers.

In 2004, the Bolivian government allowed registered farmers in the Chapare to cultivate 1,600 m² of coca for the legal market, shifting away from defining coca growers as active participants in the illegal drug trade to identify them as subsistence farmers working to feed their families. Article 384 of the 2009 Constitution defends coca in its natural state, asserting its cultural significance and granting it legal protection.⁶³⁵ In an effort to address the tensions between the licit national coca market and the international drug control regime, Bolivia withdrew from the 1961 Single Convention on Narcotic Drugs in 2011 and re-acceded it a year later with a reservation allowing coca cultivation and sales for cultural, medicinal and traditional uses.⁶³⁶

In 2010, the government implemented a participatory Community Control Support Programme, based on sovereignty, shared responsibility and respect for human rights.⁶³⁷ The 2017 General Coca Law further differentiated coca from cocaine, decriminalising coca cultivation with the

hope of reducing the stigma surrounding coca cultivation. The Bolivian model for community coca control has promoted:

- A reduction in illegal crop cultivation via a development strategy seeking to address affected communities' basic needs and by limiting repression⁶³⁸
- Citizenship and access to information, empowering and involving communities in the formulation and implementation of development policies, providing subsistence income through legal plots, while working to voluntarily reduce excess coca production and diversifying their economy⁶³⁹
- Development and poverty alleviation in coca growing regions by strengthening public services and institutional frameworks for marginalised communities⁶⁴⁰
- Respect for the fundamental human rights and wellbeing of families and vulnerable communities, preventing illegal cultivation of coca, while taking into account traditional licit uses⁶⁴¹
- Cooperation between farmers, the state, and international stakeholders such as the EU and the UNODC to develop crop monitoring systems and impact assessment tools focusing on broader development considerations.⁶⁴²

Bolivia's community coca control



Regulated legal cultivation

Registered growers can grow on a limited extension of land.



Investment in development

Non-conditional support in coca-growing areas.



Enforced regularly

By both local growers unions and state agencies.



Constitutional protection

The Constitution asserts the plant's cultural significance.

Credit: Juan Fernandez Ochoa, IDPC

2.3.5 Protecting the environment in drug control strategies

2009 Political Declaration and Plan of Action

Action 22(e): 'Promote supply reduction measures that take due account of traditional licit uses, where there is historical evidence of such use, as well as environmental protection, in conformity with the United Nations Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances of 1988'

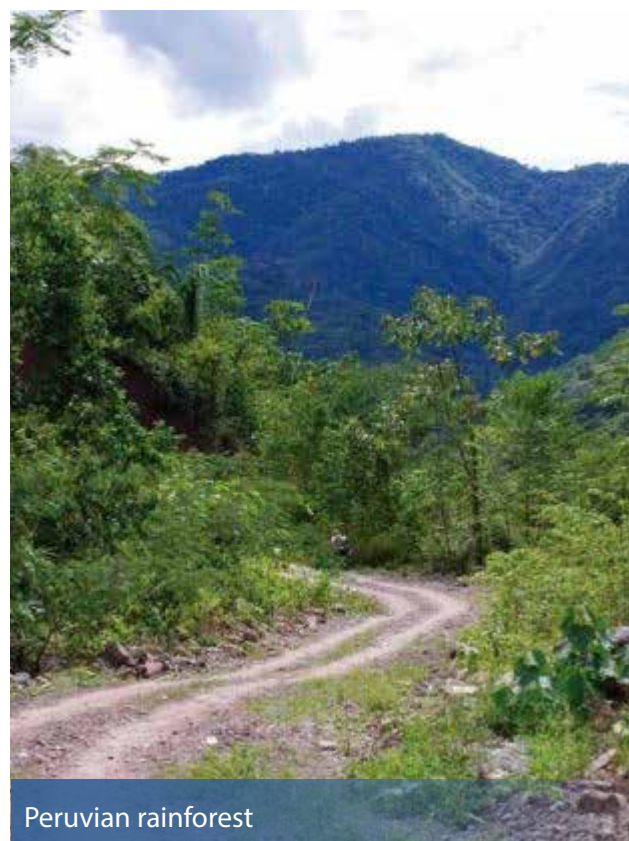
Action 49(e): 'Ensure that development partners, affected States and other relevant key development actors examine innovative ways to promote alternative development programmes, including preventive alternative development programmes, where appropriate, that are environmentally friendly'

In various areas, illegal crop cultivation has contributed to the deforestation and degradation of the environment because of the chemicals used to grow and process crops, such as agrochemicals, sulfuric acid, kerosene and others, being discharged into soil and streams.⁶⁴³ This, however, is not limited to the cultivation of crops destined for the illegal drug market, with similar environmental harms associated with many other forms of agriculture. Rather than minimising harms to the environment, forced crop eradication campaigns have exacerbated environmental damage, by displacing subsistence farmers into new, more remote environments, including national parks and indigenous territories.⁶⁴⁴ In Colombia, for instance, the UNODC estimated in 2016 that 32% of coca was being cultivated in national parks, indigenous reserves and Afro-Colombian Community Lands, and that the areas cultivated within these territories had been in 'constant increase in the last years'.⁶⁴⁵

The use of harmful pesticides to destroy crops destined for the illegal drug market has also damaged fish and other aquatic life due to contaminated water, as well as fauna, insects and soil composition.⁶⁴⁶ The destruction of natural habitats and tropical ecosystems is likely to result in harms to native species.⁶⁴⁷ In recognition of concerns over both human and environmental harms, Peru, Bolivia, Ecuador and Thailand have all banned the use of chemical agents in eradication efforts.⁶⁴⁸ Colombia's discontinuation of aerial spraying is likely to be reversed under the new government, while substances like glyphosate⁶⁴⁹ continue to be used for manual fumigation.⁶⁵⁰

A 2015 report by Open Society Foundations concluded that there was 'little evidence' to suggest that alternative development programmes would alleviate the environmental impacts of drug crop eradication. For instance, in reference to Colombia and Bolivia, researchers found that 'under alternative development initiatives, coca farmers cleared *more* primary forest to plant "land hungry substitute crops" that could not be cultivated as intensively as coca'. The report also concluded that 'The loss of forests and the degradation of natural habitats in drug production and drug trafficking zones contributes to the crisis of biodiversity decline worldwide'.⁶⁵² It should be recalled here that forest conservation is essential to tackling climate change, since 11% of global emissions originate from deforestation.⁶⁵³ Nevertheless, environment protection is barely discussed at the CND, while discussions at the High Level Political Forums on the SDGs, at the UN Framework Convention on Climate Change or within the UN Environment Programme have so far largely ignored the links between drug control and environment degradation.

In recognition of this worrying trend, the UNODC reported that since 2010 an increasing number of member states have included environmental conservation in their alternative development strategies. This includes reforestation, soil restoration, the use of bio-fertilisers, the diversification of crops, organic production, and more rarely ecotourism.⁶⁵⁴



Peruvian rainforest

Credit: Health Poverty Action

The need to ensure 'environmental sustainability' is also recognised within paragraph 7.g of the UN-GASS Outcome Document.⁶⁵⁵

As an example, Thailand has incorporated a strong environment protection component in its alternative development strategy, including in land distribution, which areas should be cultivated and which should be reforested, how to use natural resources sustainably, etc. The programme also includes environmental education 'so that new generations can continue to be stewards of environmental sustainability'.⁶⁵⁶ Similarly, in Colombia the UNODC – with support from GPPD and the climate protection project REDD+⁶⁵⁷ – has conducted a comprehensive analysis of the environmental impact of coca cultivation in the country, offering a set of criteria and recommendations to address this critical issue, including the use of traditional production models, as well as the creation of partnerships with affected communities.⁶⁵⁸

2.3.6 Ensuring that development assistance protects human rights

2009 Political Declaration and Plan of Action

Action 47(c): 'Ensure that development assistance provided to communities in areas affected by illicit cultivation of crops used for the production of narcotic drugs and psychotropic substances takes into account the overall aims of human rights protection and poverty eradication'

Until recently, the links between drugs and development have been largely misunderstood and have generally been ignored by international donors. In other cases, foreign aid has been conditioned to the adoption of a drug control approach by recipient countries, including eradicating all cultivation prior

to receiving any development assistance, resulting in a variety of human rights violations. In Afghanistan, for instance, militarised interventions funded first by the USA and then by the Russian Federation have resulted in a more precarious security situation with increased levels of crime, an ongoing Taliban insurgency and official and unofficial militias remaining active in the region – with severe consequences for subsistence farmers.⁶⁵⁹ A 2017 Brookings Institution report found that this had resulted in increased support from the population to the Taliban which provides armed security, jobs and subsistence, especially in remote rural areas of the country.⁶⁶⁰ The recent shift towards broader development strategies in illegal crop production areas by donors like GIZ and the European Union is therefore welcome, but remains the exception.

References to human rights and alternative development are often put in the context of ensuring that human rights are taken into account in implementing drug control programmes. These, however, are not policy choices per se, but rather obligations that need to be respected. Eradication prior to the establishment of alternative livelihoods pushes people deeper into poverty, and fosters human rights violations, social unrest, instability and violence, among other negative impacts. It exacerbates stigmatisation and marginalisation of small-scale producers, and can result in imprisonment, displacement, and the criminalisation of indigenous and traditional cultural practices. According to the Transnational Institute: 'People have the right to be free from hunger, to an adequate standard of living, to live a life in dignity, and to social security. When states fail in meeting their obligations to secure these rights, a strong argument can be made that they cannot interfere when people as a consequence are forced to find their own ways to do so, even if that means their involvement in illicit cultivation in absence of viable licit alternatives.'⁶⁶¹

Part 3:

What next?

Designing new benchmarks for global drug policy

1 The UNGASS Outcome Document as a policy framework beyond 2019

'The cross-cutting UNGASS 2016 approach constitutes a new and better linkage of the objective of drug-control – protection of the health and welfare of humanity – with the key priorities of the UN system, including the SDGs. I encourage the continuation of this structure for future UN drug policy debates', UN High Commissioner for Human Rights, 2018⁶⁶²

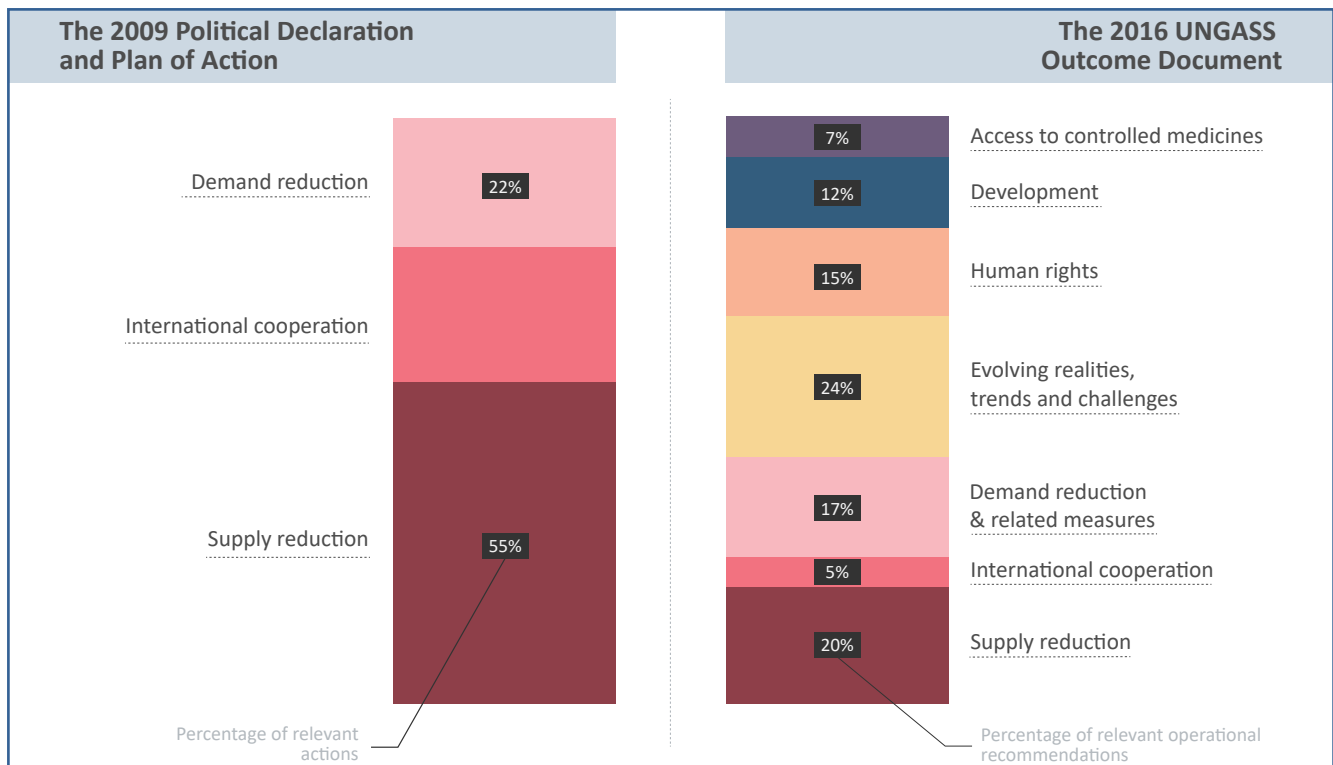
When it was adopted in April 2016, the UNGASS Outcome Document was criticised by civil society⁶⁶³ and a number of government officials⁶⁶⁴ for failing to question the punitive approach to global drug control, and for failing to mention decriminalisation and the abolition of the death penalty for drug offences, among other issues. The call, in the preamble of the Outcome Document, for the achievement of a 'society free of drug abuse', remains particularly problematic considering the lack of progress and severe consequences associated with efforts to achieve this goal over the past 10 years. Perhaps unsurprisingly, the issue of reg-

ulated markets for certain substances likewise did not make it into the final document (see [Box 21](#)).

Initial analysis by IDPC – to be published later in 2018 – confirms that all recommendations and thematic areas covered in the 2009 Political Declaration and Plan of Action were also incorporated in the Outcome Document, apart from one issue (witness protection, mentioned in Paragraphs 61 and 62 of the Plan of Action). Both the spirit and themes of the 2009 Political Declaration are therefore largely reflected within in the 2016 Outcome Document.

Nonetheless, in many regards the Outcome Document represents a significant improvement over past high-level drug policy documents – including the 2009 Political Declaration and its plan of action. Indeed, a number of critical drug policy issues which were either not included or only partially covered in 2009 were incorporated in the 2016 document. This includes issues affecting women and

Figure 13. Comparing the structure and number of actions/recommendations of the 2009 Plan of Action with that of the 2016 UNGASS Outcome Document⁶⁶⁵



Credit: Juan Fernandez Ochoa, IDPC

Box 21 The UN drug control conventions and the legal regulation of cannabis for non-medical use

One of the greatest disconnects between contemporary reality and the UN's 2019 drug policy targets has to do with cannabis. The UN drug control treaties expressly limit cannabis use to medical and scientific purposes, and cannabis is placed under the strictest of the conventions' control schedules, meaning that its liability 'to abuse and to produce ill effects... is not offset by substantial therapeutic advantages'. However, cannabis is by far the world's most widely used illegal drug.⁶⁶⁶ Instead of persisting with efforts to ban cannabis markets, an increasing number of jurisdictions are choosing to provide for legal, regulated access to cannabis for adults for non-medical purposes. These jurisdictions have concluded – in some cases by public ballot – that regulation would be better suited to promote the health, security, and human rights of their citizens.

Movement toward regulation of non-medical cannabis is most obvious in the Americas, namely in Uruguay,⁶⁶⁷ Canada,⁶⁶⁸ and the USA,⁶⁶⁹ and these policy shifts are prompting renewed debate on cannabis regulation elsewhere in the world, such as in the Netherlands,⁶⁷⁰ Switzerland⁶⁷¹ and New Zealand.⁶⁷² In the Caribbean, where Jamaica already allows for cannabis use in religious ceremonies⁶⁷³ and St Vincent and the Grenadines is about to adopt a similar bill, a recent report of the Caribbean Community (CARICOM) Regional Commission on Marijuana recommends that 'the end-goals for CARICOM should be the removal of a prohibitionist regime that has proven to be ineffective, unjust and caused more harm than it sought to prevent' and that 'CARICOM Member States should negotiate the tensions arising between redundant treaties and other requirements, not unilaterally, but as a unified entity'.⁶⁷⁴

There is little doubt that legal regulation of non-medical cannabis is beyond the bounds of what the drug control treaties permit. But regulation is moving ahead all the same, and the resulting treaty tensions are now a matter of intense debate at UN drug policy forums.⁶⁷⁵ The so-called 'Vienna consensus' is fractured, and the starkly different approaches to cannabis are among the key reasons why. Reaching

a new global consensus to revise or amend the UN drug control conventions in order to accommodate legally regulated markets for cannabis does not appear to be a viable scenario for the foreseeable future. Meanwhile, the limits of flexible treaty interpretations have been reached, and overstressing them any further would result in undermining the basic principles of international law. States that intend to move towards legal regulation, or that have already done so, are therefore obliged to explore other options to reconcile such policy changes with their obligations under international law. Only a few options are available that do not require the consent of all the treaty parties.

The WHO can recommend, after a critical review by its ECDD, to change the schedule of a controlled substance or remove it from the schedules altogether, and the CND is then asked to adopt the recommendation by a simple or two-thirds majority vote (for the 1961 and 1971 conventions, respectively). The ECDD's first-ever critical review of cannabis is indeed underway.⁶⁷⁶ This review is likely to result in WHO recommendations by the end of the year to re-schedule cannabis (plant, resin and extracts) within the 1961 treaty and its active THC compounds within the 1971 treaty, although reaching the required CND majority to adopt them may prove difficult. The other options that do not require UN consensus are either a unilateral procedure by late reservations to the treaties or denunciation and re-accession with new reservations (as Bolivia did with regard to coca), or collective *inter se* modifications negotiated between like-minded countries – a procedure provided for under Article 41 of the Vienna Convention on the Law of Treaties.⁶⁷⁷

The *inter se* procedure was specifically designed to find a balance between the stability of treaty regimes and the necessity of change in the absence of consensus. This option would require the like-minded agreement to include a clear commitment to the original treaty aim to promote the health and welfare of humankind and to maintaining the original treaty obligations vis-à-vis countries not party to the *inter se* agreement. The situation in which the

Continued overleaf

UN drug control treaty regime finds itself today – systemic challenges and inconsistencies, increasing tensions with state practices, huge political and procedural obstacles to amendments, and unilateral escape attempts – merit a careful exploration of the legitimacy and viability of *inter se* agreements. As more countries

opt for legal regulation of cannabis, the coordinated collective response entailed by *inter se* agreements has clear benefits compared to a chaotic scenario of a growing number of different unilateral reservations and questionable re-interpretations.⁶⁷⁸

children, key harm reduction interventions (such as overdose prevention and NSPs, although the term ‘harm reduction’ failed once again to feature in the final text), proportionality of sentencing, key human rights issues (including the right to a fair trial and due process, to be free from torture and cruel punishment, among others), as well as developmental considerations with a strong link to the need to alleviate poverty and to achieve the SDGs in both rural and urban settings. Finally, it is worth noting that the UNGASS Outcome Document does not include the unrealistic drug-free world targets that were incorporated in both the 1998 and 2009 Political Declarations. This omission leaves the door open to consider new metrics and indicators through which progress can be evaluated.

The seven-pillar structure of the Outcome Document (i.e. demand reduction, supply reduction, international cooperation, access to controlled medicines, human rights, evolving realities, trends and challenges, and development) is also a welcome departure from the siloed three-pillar approach

of the 2009 Declaration (i.e. demand reduction, supply reduction and international cooperation). In addition to better reflecting the complexities of the illegal drug market, this new structure enables member states to address a broader range of drug policy issues that do not fit under the headings of ‘demand reduction’, ‘supply reduction’ and ‘Countering money-laundering and promoting judicial cooperation to enhance international cooperation’. The inclusion of separate chapters on access to controlled medicines, human rights and development are particularly important for drug control to better contribute to the broader UN objectives of protecting human rights, peace and security, and development.

Furthermore, the level of visibility allocated to each of the seven themes within the Outcome Document is much more balanced than in 2009. Then, the Plan of Action included 122 actions to reduce supply compared to only 50 on demand reduction. In comparison, the Outcome Document provides a much more balanced alternative (see Figure 13).

2 The 2019 Ministerial Segment: Establishing a timeline for the next decade

The 2019 Ministerial Segment is a critical moment to take stock of what has – and has not – been achieved over the past decade, as well as to build on the important progress reflected in the UNGASS Outcome Document. It is also a key opportunity to re-orientate international drug policy away from harmful punitive approaches towards more effective and humane policies. Ahead of the Segment, the IDPC network⁶⁷⁹ developed four recommendations to inform the 2019 event and global drug policy going forward.

2.1 Moving away from 'drug-free world' targets

The data presented in this Shadow Report show that the targets aiming to ‘eliminate or reduce significantly and measurably’ the illegal drug market have failed to materialise. Over the past decade, these targets have distorted policy priorities, diverting funding away from proven public health and development approaches, and have been used to justify a number of human rights abuses. Beyond 2019, the international commu-

nity should consider adopting more meaningful goals and targets in line with the 2030 Agenda for Sustainable Development, the UNGASS Outcome Document and international human rights commitments. Examples of possible new targets are available below.

2.2 Meaningfully reflect the impacts of drug policies on the UN goals of promoting health, human rights, development, peace and security

Most drug policies worldwide have undermined or run counter to the overarching priorities of the UN to protect human rights, consolidate peace and security and advance development. Undeniable progress has been made within the UNGASS Outcome Document to better reflect these key priorities, in particular with references to the SDGs. Going forward, the overall objective of global drug policies should actively seek to contribute to advancing the 2030 Agenda for Sustainable Development, including protecting basic



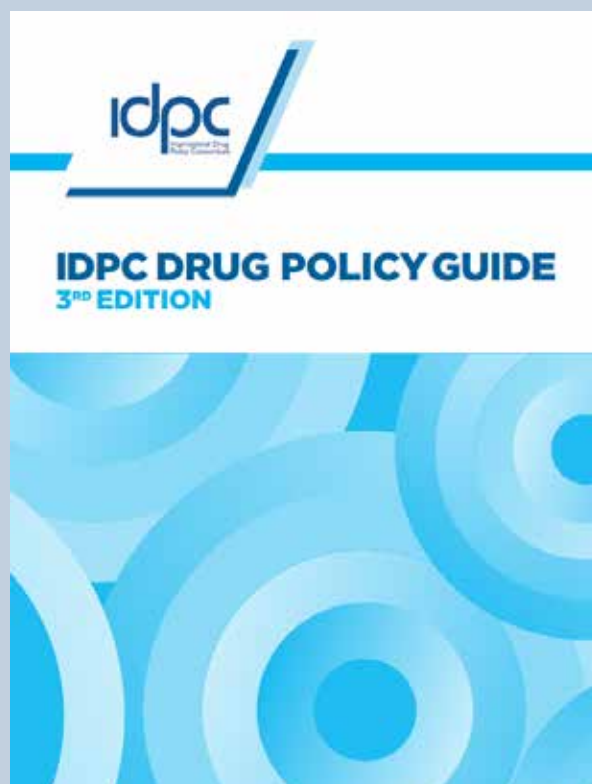
Box 22 Options for drug policy reform

Ahead of the 2016 UNGASS, IDPC released the third edition of its Drug Policy Guide.⁶⁸⁰ Bringing together global evidence and best practices, the Guide provides expert analysis across the spectrum of drug policy, including on aspects related to public health, criminal justice and development. Each theme explores the latest available evidence of effectiveness, illustrated by country case studies, and offers advice and recommendations for effective, balanced and humane drug policies. These include:

- The scale up, expansion and funding of evidence-based drug prevention, harm reduction and drug dependence treatment services in the community and in prison settings
- The removal of legislative, regulatory and technical barriers that hampers access to controlled medicines, especially in the Global South
- The decriminalisation of people who use drugs and subsistence farmers engaged in illegal crop cultivation
- The consideration of legally regulated markets to address the harms associated with punitive drug control, in particular mass incarceration, human rights abuses, stigma and discrimination
- The use of effective and humane alternatives to incarceration for non-violent drug offenders, and the review of current drug laws to ensure more proportionate sentencing for all drug offences
- The abolition of the death penalty for drug offences
- The incorporation of a development perspective in drug policies to address poverty,

marginalisation and vulnerability, with the goal of leaving no one behind

- The recognition and protection of the rights of indigenous peoples, including the right to grow and use internationally controlled substances
- The consideration of new metrics and indicators to measure the effectiveness of drug policy, using the Human Rights Index and the SDGs
- The inclusion of civil society, in particular affected communities, in all aspects of the design, implementation, monitoring and evaluation of drug policy.⁶⁸¹



human rights, strengthening good governance and promoting the well-being of society, especially those most marginalised and vulnerable.

2.3 Reflecting the realities of drug policies on the ground, both positive and negative

The Shadow Report highlights significant changes in the global drug policy landscape since 2009, with unprecedented reforms taking place at local

and national levels in the fields of harm reduction, treatment, decriminalisation, alternatives to incarceration, medicinal cannabis, and the creation of legally regulated markets for non-medical use, among others. 2019 will be a critical juncture at which these reforms should be discussed, in particular with regards to the possible resulting tensions with the international drug control regime (see [Box 21](#)). On the other side of the policy spectrum, it is equally important to acknowledge the human rights abuses committed in the name

of drug control, including the continued use of the death penalty for drug offences, extrajudicial killings, compulsory detention centres, mass incarceration and dire prison conditions, stigma and discrimination against people who use drugs, and others. These serious human rights concerns should feature prominently in the 2019 debates to ensure a paradigm shift in drug policy that is enshrined in international human rights law, health and social inclusion.

2.4 Ending punitive approaches and putting people and communities first

This Shadow Report has showcased how drug policies have so far placed a disproportionate emphasis on the substances they seek to control, rather than on the well-being of people and communities they seek to serve. Beyond 2019, the global drug strategy should focus on putting people and communities at the centre, and seek to improve their living conditions, address their vulnerabilities and protect their human rights – in line with the SDG vision of ‘leaving no one behind’. This entails embracing a social justice

approach to drug policy, in order to redress some of the social harms associated with punitive drug control. Putting people first also requires that the UN address the ongoing tensions between UN drug control obligations and the rights of indigenous peoples. In this context, a rights-centred approach should aim to protect the traditional and medicinal practices of indigenous communities, including their right to cultivate and use controlled substances.

This shift in focus requires civil society and community involvement in all aspects of the design, implementation, evaluation and monitoring of drug policies at local, national, regional and international levels. This imperative had already been recognised within the 2009 Political Declaration and Plan of Action (Actions 10 and 12(b)) and was reiterated in the 2016 UNGASS Outcome Document (Preamble and paragraphs 1.q, 4.g, 7.l and 9). Beyond 2019, global drug policy should include the continued and meaningful participation of most affected groups, in particular people who use drugs, people involved in subsistence farming of crops destined for the illegal drug market, formerly incarcerated drug offenders, indigenous peoples, and other communities such as affected women, children and youth.

3 Identifying new indicators for measuring the success of drug policy: How to leverage the Sustainable Development Goals

The success of drug control strategies should be measured through an assessment of the impact of drug control efforts in the enjoyment of human rights and other critical aspects such as security, health and social-economic development', OHCHR, 2018⁶⁸²

Reconsidering the overall goals of global drug policy beyond the mere objective of achieving a drug-free society entails a rethink of the metrics and indicators being used to evaluate progress achieved by drug policies and strategies worldwide. If drug control no longer has a singular focus on reducing cultivation, trafficking and use – objectives that have not been achieved over the past 20 years – but rather on minimising drug-related health harms, improving access to healthcare, upholding basic human rights, reducing poverty in cultivation and trafficking areas, improving citizen safety and reducing corruption, the use of indicators focusing on measuring the scale of the illegal drug market will no longer be enough. Furthermore, the additional thematic areas covered in the UNGASS Outcome Document require the development of additional indicators to measure progress, and their inclusion in a revised ARQ. Finally, the adoption of the SDGs in 2015 poses an additional layer

of complexity, requiring the UN and its member states to recalibrate their policies – including those relating to drug control – to achieve the 2030 Agenda for Sustainable Development. By continuing to promote drug-free targets while side-lining other critical aspects of drug policy, governments may run the risk of failing to achieve many of the SDGs agreed upon in 2015.

The difficulty now lies in defining which new metrics and indicators member states and the UN should use to measure progress. The SDGs are highlighted within the UNGASS Outcome Document's preamble and paragraph 7.g. The Goals, along with their detailed targets and indicators, provide an invaluable resource for every aspect of policy making at the UN level. The interrelationship between the SDGs and drug policy has been extensively discussed elsewhere⁶⁸³ and this analysis will therefore not be repeated here. Instead, this section proposes possible new metrics and indicators based on the SDGs and closely aligned with the UNGASS Outcome Document's operational recommendations. While not every SDG may be relevant to drug policy, the targets and indicators they provide can be used and adapted to meas-



Credit: Sustainable Development Goals website

ure the success of drug policies, strategies and programmes. This is also an opportunity to identify 'outcome' or 'impact' metrics and indicators, instead of solely using 'process' or 'activity' indicators. These proposed indicators are based upon

the work currently being undergone by NGOs, UN agencies and government bodies on the issue, and aim to offer a starting point for further discussion on the matter.⁶⁸⁴

3.1 Chapter 1: Demand reduction and related measures

The current UNODC data reporting mechanism already covers levels of drug use and dependence, as well as some drug use-related health issues. However, various SDG targets and indicators may be helpful to consider, in particular to track progress in removing the political, legislative and practical barriers (including discrimination, cases of abuse, lack of adequate services, etc.) hampering access to healthcare settings:

Original SDG target/indicator	Possible drug policy target/indicator & relevant paragraph in the UNGASS Outcome Document
Indicator 1.1.1: Proportion of population below the international poverty line, by sex, age, employment status and geographical location (urban/rural)	Proportion of people who use drugs below the international poverty line, by sex, age, employment status and geographical location (urban/rural) (para 1.h)
Target 3.3: By 2030 end the epidemics of AIDS, tuberculosis, malaria, and neglected tropical diseases and combat hepatitis, water-borne diseases, and other communicable diseases	By 2030 end the epidemics of AIDS, tuberculosis and combat hepatitis and other communicable diseases among people who inject drugs (para 1.o)
Indicator 3.3.1: Number of new HIV infections per 1,000 uninfected population, by sex, age and key populations	Number of new HIV infections per 1,000 uninfected people who inject drugs, by sex, age (para 1.o)
	Number of people who inject drugs living with HIV under ART, by sex, age (para 1.o)
Indicator 3.3.2: Tuberculosis incidence per 1,000 population	Tuberculosis per 1,000 people who inject drugs, by sex, age (para 1.o)
	Proportion/Number of people who inject drugs infected by tuberculosis who have been treated and cured, by sex, age (para 1.o)
Indicator 3.3.4: Hepatitis B incidence per 100,000 population	Hepatitis B and C ⁶⁸⁵ incidence per 100,000 people who inject drugs, by sex, age (para 1.o)
	Number of people who inject drugs infected by hepatitis B and C under treatment, by sex, age (para 1.o)
Target 3.5: Strengthen prevention and treatment of substance abuse, including narcotic drug abuse and harmful use of alcohol	Adoption of minimum quality standards for drug prevention and treatment, modelled on those developed by UNODC (para 1.h)
Indicator 3.5.1: Coverage of treatment interventions (pharmaceutical, psychosocial and rehabilitation and aftercare services) for substance use disorders	Coverage of treatment interventions (pharmaceutical, psychosocial and rehabilitation and aftercare services) for drug dependency both in the community and in prison, by sex, age (para 1.j, 4.m)
	Proportion/number of people dependent on drugs accessing voluntary and evidence-based drug dependence treatment, number of those having completed their treatment, and retention rate, by sex, age (para 1.j)
Indicator 10.3.1: Proportion of the population reporting having personally felt discriminated against or harassed within the previous 12 months on the basis of a ground of discrimination prohibited under international human rights law	Proportion/number of people who use drugs reporting having personally felt discriminated against or harassed within the previous 12 months on the basis of a ground of discrimination prohibited under international human rights law, by sex, age (para 1.j)
Indicator 11.7.2: Proportion of persons victim of physical or sexual harassment, by sex, age, disability status and place of occurrence, in the previous 12 months	Proportion/number of people who use drugs victim of physical or sexual harassment, by sex, age, disability status and place of occurrence, in the previous 12 months (para 4.c)

3.2 Chapter 2: Ensuring access to controlled medicines

The issue of improving access to controlled medicines was only covered in one action in the 2009 Political Declaration and Plan of Action, but was allocated an entire chapter in the UNGASS Outcome Document. This is a key opportunity for member states to report on progress made in this regard. Within the SDGs, two targets are particularly relevant for this topic:

Original SDG target/indicator	Possible drug policy target/indicator & relevant paragraph in the UNGASS Outcome Document
Target 3.5: Strengthen prevention and treatment of substance abuse, including narcotic drug abuse and harmful use of alcohol	Ensure access to controlled medicines included in the WHO Model List of Essential Medicines for the treatment of drug dependence, including methadone, buprenorphine and morphine (para 2.a, 1.k, 1.o))
	% of people dependent on opioids receiving substitution therapy with methadone, buprenorphine or morphine, in the community and in prison, by sex, age (para 1.k, 1.o, 2.a, 4.b, 4.m)
	Availability of naloxone (among peers, in hospitals, in healthcare facilities, etc.) (para 1.m)
Target 3.8 Achieve universal health coverage (UHC), including financial risk protection, access to quality essential health care services, and access to safe, effective, quality, and affordable essential medicines and vaccines for all	Achieve universal health coverage, including access to essential healthcare services, and access to safe, effective, quality and affordable essential medicines for all (para 2)
	Legislation or regulations to improve access to controlled substances for medical and scientific purposes (e.g. substances available, requirements to prescribe; requirements for patients to obtain prior permission or register to be eligible, for physicians to receive special licences, for pharmacies to obtain prior licences to dispense medicines, etc.) (para 2, 2.a)
	% of people suffering from moderate to severe or chronic pain receiving controlled medicines, by sex, age (para 2)
	Number of pharmaceutical establishments that can dispense opioids for pain management per 100,000 inhabitants (para 2.a, 2.d)
	% of medical and nursing schools providing palliative care and pain management training in their curriculum (para 2.e)
	Coverage of training for healthcare professionals on palliative care and the treatment of moderate to severe or chronic pain with controlled medicines (para 2.e)

3.3 Chapter 3: Supply reduction and related measures

Progress in supply reduction has so far mostly been measured according to process indicators tracking numbers of seizures of drugs, crops eradicated and arrests of cultivators, traffickers and dealers. The UNGASS Outcome Document provides an opportunity to develop new indicators assessing the socio-economic conditions of vulnerable communities (para 3.b) and measuring evolutions in levels of violence and corruption, using the following SDG targets and indicators:

Original SDG target/indicator	Possible drug policy target/indicator & relevant paragraph in the UNGASS Outcome Document
Indicator 1.1.1: Proportion of population below the international poverty line, by sex, age, employment status and geographical location (urban/rural)	Proportion of population below the international poverty line in areas affected by illegal drug cultivation, production, trafficking and sale, by sex, age (urban/rural) (para 3.b)
Target 16.1: Significantly reduce all forms of violence and related death rates everywhere	Significantly reduce all forms of violence and related death rates in areas affected by illegal drug cultivation, production, trafficking and sale (para 3.a)
Indicator 16.1.1: Number of victims of intentional homicide per 100,000 population, by sex and age	Numbers of victims of intentional homicide per 100,000 population in areas affected by illegal drug cultivation, production, trafficking and sale, by sex and age (para 3.a)
Target 16.5: Substantially reduce corruption and bribery in all their forms	Significantly reduce corruption and bribery in areas affected by illegal drug cultivation, production, trafficking and sale (para 3.a)
	Increased number of financial investigations and confiscations in relation to the proceeds of drug-related organised crime (para 3.q, 3.r)
	Perception of public sector corruption (para 3.a)
	Number of investigations and prosecutions for drug-related corruption and/or money-laundering cases involving governments (para 3.f)

3.4 Chapter 4: Human rights, youth, children, women and communities

The Outcome Document is the first example in the history of international drug control of a high-level document dedicating a whole chapter to human rights. Despite the sensitivities associated with the issue throughout the negotiations of the Outcome Document, this chapter includes key operational recommendations on proportionality of sentencing, due process, the prevention of torture and ill-treatment, as well as the rights of women and children. This provides an opportunity to develop indicators through which member states – but also UN agencies and civil society – may report back on progress, or lack thereof, towards the achievement of the following SDG targets and indicators:

Original SDG target/indicator	Possible drug policy target/indicator & relevant paragraph in the UNGASS Outcome Document
Target 1.1: By 2030, eradicate extreme poverty for all people everywhere, currently measured as people living on less than \$1.25 a day	Number of people incarcerated for drug offences living below the poverty line and who are the sole care provider of children and other dependent relatives (para 4.d)
Target 3.3: By 2030, end the epidemics of AIDS, tuberculosis, malaria and neglected tropical diseases and combat hepatitis, water-borne diseases and other communicable diseases	Availability and coverage of gender-sensitive harm reduction interventions in the community and in prison settings (para 1.k, 1, o, 4.b)
Indicator 3.5.1: Coverage of treatment interventions (pharmacological, psychosocial and rehabilitation and aftercare services) for substance use disorders	Availability and coverage of gender-sensitive treatment interventions (pharmacological, psychosocial and rehabilitation and aftercare services) in the community and in prison settings (para 1.i, 4.m, 4.o)
Target 5.1: End all forms of discrimination against all women and girls everywhere	Reported cases of stigma and discrimination in accessing healthcare services by women who use drugs (para 4.b)
Indicator 5.1.1: Indicator 5.1.1: Whether or not legal frameworks are in place to promote, enforce and monitor equality and non-discrimination on the basis of sex	Legal framework adopted/in place to monitor and redress cases of discrimination against women and girls who use drugs (para 4.b)
Target 5.2: Eliminate all forms of violence against all women and girls in the public and private spheres, including trafficking and sexual and other types of exploitation	See Indicator 5.2.2
Indicator 5.2.2: Proportion of women and girls aged 15 years and older subjected to sexual violence by persons other than an intimate partner in the previous 12 months, by age and place of occurrence	Reported cases of sexual violence against women and girls who use drugs and female drug offenders (para 4.d)
Target 5.C: Adopt and strengthen sound policies and enforceable legislation for the promotion of gender equality and the empowerment of all women and girls at all levels	Legislation, regulation or measure passed/reviewed to ensure a gender-sensitive approach to drug policies and programmes, including in the implementation of the Bangkok Rules (para 4.n)
Target 10.3: Ensure equal opportunity and reduce inequalities of outcome, including by eliminating discriminatory laws, policies and practices and promoting appropriate legislation, policies and action in this regard	Legal and/or policy framework adopted/in place to monitor and redress cases of discrimination against people who use drugs and drug offenders (paras 4.b, 4.d, 4.g)
Target 10.3.1: Proportion of the population reporting having personally felt discriminated against or harassed within the previous 12 months on the basis of a ground of discrimination prohibited under international human rights law	Reported cases of stigma and discrimination in accessing healthcare services, by sex, age (paras 1.k, 4.b, 4.d)
Indicator 11.7.2: Proportion of persons victim of physical or sexual harassment, by sex, age, disability status and place of occurrence, in the previous 12 months	Reported cases of sexual violence against people who use drugs, by sex, age (para 4.d)

Continued overleaf

Target 16.1: Significantly reduce all forms of violence and related death rates everywhere	Reported cases of violence against, and extrajudicial killings of, suspected drug offenders, by sex, age (para 4.o)
Indicator 16.1.3: Proportion of population subjected to physical, psychological or sexual violence in the previous 12 months	Legislation, regulation or measure passed to eliminate acts of ill-treatment or punishment against drug offenders, by sex, age (para 4.c, 4.o)
	Incidence and prevalence of physical and psychological abuse, including by law enforcement officials, against (suspected) drug offenders, by sex, age (para 4.o)
Target 16.2: End abuse, exploitation, trafficking and all forms of violence against and torture of children	Reported cases of abuse, exploitation, trafficking and violence by drug traffickers and organised crime organisations against children and youth involved in illegal drug activities, by sex (para 4.d, 4.f)
	Reported cases of abuse and violence by police and law enforcement officers against children and youth involved in illegal activities, by sex (para 4.d, 4.f)
Target 16.3: Promote the rule of law at the national and international levels and ensure equal access to justice for all	Legislation, regulation or measure passed/reviewed to ensure more proportionate penalties and alternatives to incarceration for drug offences (para 4.l, 4.j)
	Legislation, regulation or measure passed to eliminate impunity (para 4.o)
	Reported cases of arbitrary detention, by sex, age (para 4.o)
	Proportion of victims of ill-treatment or punishment accused of drug offences who have received compensation and rehabilitation, by sex, age (para 4.c, 4.o)
	% of people accused of drug offences who received legal aid during trial (para 4.o)
Indicator 16.3.2: Unsentenced detainees as a proportion of overall prison population	Proportion of drug offenders held in pre-trial detention, by sex, age (para 4.j)
Target 16.7: Ensure responsive, inclusive, participatory and representative decision-making at all levels	Legislation, regulation or measure passed/reviewed to ensure the involvement of affected communities in the development, implementation, monitoring and evaluation of drug policies and programmes (para 4.b)

3.5 Chapter 5: Evolving reality, trends and existing circumstances

In an increasingly complex and fast-evolving global drug market, this chapter of the UNGASS Outcome Document is critical, in particular with regards to responding to the possible health and social harms associated with NPS and ATS. Much of the recommendations within this chapter relate to supply reduction efforts, but several also focus on health. In this regard, the following SDG targets may be useful:

Original SDG target/indicator	Possible drug policy target/indicator & relevant paragraph in the UNGASS Outcome Document
Target 3.3: By 2030, end the epidemics of AIDS, tuberculosis, malaria and neglected tropical diseases and combat hepatitis, water-borne diseases and other communicable diseases	By 2030, end the epidemics of AIDS, tuberculosis and combat hepatitis and other communicable diseases among people using NPS or ATS (para 5.d) Availability of innovative, accessible interventions to address the adverse health consequences of NPS and ATS use (para 5.d)
Indicator 3.3.1: Number of new HIV infections per 1,000 uninfected population, by sex, age and key populations	Number of new HIV infections per 1,000 uninfected people using NPS or ATS, by sex, age (para 5.d)
Indicator 3.3.2: Tuberculosis incidence per 1,000 population	Tuberculosis incidence per 1,000 people using NPS or ATS, by sex, age (para 5.d)
Indicator 3.3.4: Hepatitis B incidence per 100,000 population	Hepatitis B and C incidence per 100,000 people using NPS or ATS, by sex, age (para 5.d)
Target 3.5: Strengthen the prevention and treatment of substance abuse, including narcotic drug abuse and harmful use of alcohol	Proportion/number of people dependent on NPS or ATS receiving evidence-based drug dependence treatment, including substitution treatment (para 5.d) Availability of minimum quality standards for the prevention and treatment of NPS or ATS dependence (para 5.d)
Indicator 3.5.1: Coverage of treatment interventions (pharmacological, psychosocial and rehabilitation and aftercare services) for substance use disorders	% of people dependent on NPS or ATS accessing evidence-based treatment, by sex, age (para 5.d)

3.6 Chapter 6: Strengthening international cooperation

This topic is extensively covered in the 2009 Political Declaration and within the current ARQ. However, two SDG Targets may be useful to consider:

Original SDG target/indicator	Possible drug policy target/indicator & relevant paragraph in the UNGASS Outcome Document
Target 16.A: Strengthen relevant national institutions, including through international cooperation, for building capacity at all levels, in particular in developing countries, to prevent violence and combat terrorism and crime	Level of information sharing through effective coordination mechanisms at national, regional, sub-regional and international levels on expertise and best practice in drug policy (para 6.c)
Target 17.6: Enhance North-South, South-South and triangular regional and international cooperation on and access to science, technology and innovation and enhance knowledge sharing on mutually agreed terms, including through improved coordination among existing mechanisms, in particular at the United Nations level, and through a global technology facilitation mechanism	Formal and informal mechanisms established to enhance North-South, South-South and triangular cooperation among member states on drug policy (para 6.b)
Indicator 17.14.1: Number of countries with mechanisms in place to enhance policy coherence of sustainable development	Legislation, policy and/or strategy adopted and implemented to enhance policy coherence between drug control and sustainable development (para 6.d)

3.7 Chapter 7: Alternative development, development-oriented balanced drug control policy

Here again, the UNGASS Outcome Document made significant progress in expanding the concept of alternative development to include broader development considerations, including addressing socio-economic vulnerabilities, improving access to education, employment, land tenure and natural resources, addressing inequalities and protecting the environment – both in rural and urban settings. Unsurprisingly, there are many relevant SDG targets and indicators relevant to this issue:

Original SDG target/indicator	Possible drug policy target/indicator & relevant paragraph in the UNGASS Outcome Document
Target 1.1: By 2030, eradicate extreme poverty for all people everywhere, currently measured as people living on less than \$1.25 a day	By 2030, eradicate extreme poverty for people living in areas affected by illegal drug cultivation, production, trafficking and sale, currently measured as people living on less than \$1.25 a day (para 3.b, 5.v, 7.b)
Indicator 1.1.1: Proportion of population below the international poverty line, by sex, age, employment status and geographical location (urban/rural)	Proportion of people living below the poverty line in communities affected by illegal drug cultivation, production, trafficking and sale (para 3.b, 5.v, 7.b)
	Poverty level among families where illegal drug cultivation is the primary source of income (para 3.b, 5.v, 7.b)
	Poverty levels among people prosecuted/arrested for drug supply/trafficking offences (para 3.b, 5.v, 7.b)
	Comparison of poverty levels before and two years after sustainable development programmes have been implemented, in areas affected by illegal crop cultivation (para 7.b, 7.j)
Target 1.4: By 2030, ensure that all men and women, in particular the poor and the vulnerable, have equal rights to economic resources, as well as access to basic services, ownership and control over land and other forms of property, inheritance, natural resources, appropriate new technology and financial services, including microfinance	By 2030 ensure that all men and women, particularly the poor and the vulnerable in areas affected by illegal drug cultivation, production, trafficking and sale, have equal rights to economic resources, as well as access to basic services, ownership, and control over land and other forms of property, inheritance, natural resources, appropriate new technology, and financial services including microfinance (para 7.j)
	Increase/reduction in the number of people displaced from their land due to crop eradication activities and other drug law enforcement efforts (para 7.j)
Indicator 1.4.2: Proportion of total adult population with secure tenure rights to land, with legally recognized documentation and who perceive their rights to land as secure, by sex and by type of tenure	Percentage of women, men, indigenous peoples, and local communities in areas affected by illegal drug cultivation, production, trafficking and sale with secure rights to land, property, and natural resources, measured by (i) percentage with documented or recognised evidence of tenure, and (ii) percentage who perceive their rights are recognised and protected (para 7.j)
Target 4.1: By 2030, ensure that all girls and boys complete free, equitable and quality primary and secondary education leading to relevant and effective learning outcomes	By 2030, ensure that all girls and boys complete free, equitable and quality primary and secondary education leading to relevant and effective learning outcomes in areas affected by illegal drug cultivation, production, trafficking and sale (para 7.h, 7.j)
Indicator 4.3.1: Participation rate of youth and adults in formal and non-formal education and training in the previous 12 months, by sex	Percentage of people having access to primary, secondary and higher education in areas affected by illegal drug cultivation, production, trafficking and sale (para 7.h, 7.j)

Target 5.A: Undertake reforms to give women equal rights to economic resources, as well as access to ownership and control over land and other forms of property, financial services, inheritance and natural resources, in accordance with national laws	Undertake reforms to give women equal rights to economic resources, as well as access to ownership and control over land and other forms of property, financial services, inheritance and natural resources in areas affected by illegal drug cultivation, production, trafficking and sale (para 7.j)
Indicator 5.A.1: (a) Proportion of total agricultural population with ownership or secure rights over agricultural land, by sex; and (b) share of women among owners or rights-bearers of agricultural land, by type of tenure	Proportion of total agricultural population in areas affected by illegal crop cultivation with ownership or secure rights over agricultural land, by sex; and share of women among owners or rights-bearers of agricultural land, by type of tenure (para 7.j)
Indicator 5.A.2: Proportion of countries where the legal framework (including customary law) guarantees women's equal rights to land ownership and/or control	Proportion of countries affected by illegal drug cultivation, production, trafficking and sale where the legal framework (including customary law) guarantees women's equal rights to land ownership and/or control (para 7.j)
Target 6.6: By 2020, protect and restore water-related ecosystems, including mountains, forests, wetlands, rivers, aquifers and lakes	By 2020, protect and restore water-related ecosystems, including mountains, forests, wetlands, rivers, aquifers and lakes, in areas affected by illegal crop cultivation (para 7.b, 7.i, 7.g)
	Proportion of countries with alternative development programmes having incorporated environmental protection components aiming to protect and restore water-related ecosystems, including mountains, forests, wetlands, rivers, aquifers and lakes (para 7.b, 7.i, 7.g)
Indicator 8.6.1: Proportion of youth (aged 15-24 years) not in education, employment or training	Proportion of youth (aged 15-24 years) not in education, employment or training in areas affected by illegal drug cultivation, production, trafficking and sale (para 7.h, 7.j)
Target 9.3: Increase the access of small-scale industrial and other enterprises, in particular in developing countries, to financial services, including affordable credit, and their integration into value chains and markets	Proportion of the population in areas affected by illegal drug cultivation, production, trafficking and sale having increased access to small-scale industrial and other enterprises and financial services, including affordable credit, and their integration into value chains and markets (para 5.v, 7.b)
	Increase in access to licit markets for products derived from local cultivation, production and manufacture in areas affected by illegal crop cultivation (para 7.b)
Target 11.1: By 2030, ensure access for all to adequate, safe and affordable housing and basic services and upgrade slums	By 2030, ensure access for all to adequate, safe and affordable housing and basic services and upgrade slums in areas affected by illegal drug cultivation, production, trafficking and sale (para 7.h, 7.j)
	Percentage of people having access to stable housing in communities affected by illegal drug cultivation, production, trafficking and sale, by sex, age (7.h, 7.j)
Target 13.2: Integrate climate change measures into national policies, strategies and planning	Proportion of countries having integrated climate change measures into their drug policies, strategies and planning (para 7.b, 7.i, 7.g)
Indicator 15.3.1: Proportion of land that is degraded over total land area	Proportion of land that is degraded over total land area in areas affected by illegal drug cultivation, production, trafficking and sale (para 7.b, 7.i, 7.g)

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Target 16.7: Ensure responsive, inclusive, participatory and representative decision-making at all levels	Ensure responsive, inclusive, participatory and representative decision-making on drug policies, strategies and programmes at all levels (para 7.b)
	Proportion of countries having adopted mechanisms to ensure responsive, inclusive, participatory and representative decision-making at all levels in drug policies, strategies and programmes (para 7.b)
Indicator 16.7.2: Proportion of population who believe decision-making is inclusive and responsive, by sex, age, disability and population group	Proportion of population living in areas affected by illegal drug cultivation, production, trafficking and sale who believe decision-making is inclusive and responsive, by sex, age, disability and population group (para 7.b)

Annex : Actions selected from the 2009 Political Declaration and Plan of Action for the Shadow Report

HUMAN RIGHTS	
Actions from the 2009 Political Declaration and Plan of Action	Issue of relevance
Action 2(g): 'Develop and implement, in cooperation with international and regional agencies, a sound and long-term advocacy strategy, including harnessing the power of communication media, aimed at reducing discrimination that may be associated with substance abuse, promoting the concept of drug dependence as a multifactorial health and social problem and raising awareness, where appropriate, of interventions based on scientific evidence that are both effective and cost-effective'	Right to health: enhancing access to evidence-based drug prevention and right to be free from discrimination
Action 4(h): 'Consider developing a comprehensive treatment system offering a wide range of integrated pharmacological (such as detoxification and opioid agonist and antagonist maintenance) and psychosocial (such as counselling, cognitive behavioural therapy and social support) interventions based on scientific evidence and focused on the process of rehabilitation, recovery and social reintegration'	Right to health: ensuring access to evidence-based drug dependence treatment
Action 4(i): 'Strengthen their efforts aimed at reducing the adverse consequences of drug abuse for individuals and society as a whole, taking into consideration not only the prevention of related infectious diseases, such as HIV, hepatitis B and C and tuberculosis, but also all other health consequences, such as overdose, workplace and traffic accidents and somatic and psychiatric disorders, and social consequences, such as family problems, the effects of drug markets in communities and crime'	Right to health: ensuring access to harm reduction interventions
Action 6(a): 'Ensure that demand reduction measures respect human rights and the inherent dignity of all individuals and facilitate access for all drug users to prevention services and health-care and social services, with a view to social reintegration'	Right to be free from torture, cruel, inhuman treatment or punishment, right to life, right to due process and a fair trial, and right to liberty and be free from arbitrary detention
Action 10(b): 'Ensure, where appropriate, the sufficient availability of substances for medication-assisted therapy, including those within the scope of control under the international drug control conventions, as part of a comprehensive package of services for the treatment of drug dependence'	Right to health: ensuring access to harm reduction interventions and evidence-based drug dependence treatment
Action 10(c): 'Continue to comply with the procedures established under the international drug control conventions and relevant resolutions of the Economic and Social Council relating to the submission to the International Narcotics Control Board of estimates of their requirements for narcotic drugs and assessments of requirements for psychotropic substances so as to facilitate the import of the required narcotic drugs and psychotropic substances and to enable the Board, in cooperation with Governments, to maintain a balance between the demand for and the supply of those drugs and substances in order to ensure the relief of pain and suffering and the availability of medication-assisted therapy as part of a comprehensive package of services for the treatment of drug dependence, while bearing in mind, in accordance with national legislation, the World Health Organization Model List of Essential Medicines'	Right to health: improving access to controlled substances for medical purposes
Action 14(a): 'Ensure that a broad range of drug demand reduction services, including those in the areas of prevention, treatment, rehabilitation and related support services, provide approaches that serve the needs of vulnerable groups and are differentiated on the basis of scientific evidence so that they respond best to the needs of those groups, taking into account gender considerations and cultural background'	Right to health: ensuring access to drug services for women

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Action 14(b): 'Ensure that prevention programmes target and involve youth and children with a view to increasing their reach and effectiveness'	Right to health: ensuring access to drug services for children
Action 14(c): 'Provide specialized training for those who work with vulnerable groups, such as patients with psychiatric co-morbidities, minors and women, including pregnant women'	Right to health: ensuring access to drug services for women
Action 15(a): 'Working within their legal frameworks and in compliance with applicable international law, consider allowing the full implementation of drug dependence treatment and care options for offenders, in particular, when appropriate, providing treatment as an alternative to incarceration'	Right to health: ensuring access to drug services in prisons and providing alternatives to prison or punishment for people who use drugs
	Right to liberty and be free from arbitrary detention
Action 15(c): 'Implement comprehensive treatment programmes in detention facilities; commit themselves to offering a range of treatment, care and related support services to drug-dependent inmates, including those aimed at prevention of the transmission of related infectious diseases, pharmacological and psychosocial treatment and rehabilitation; and further commit themselves to providing programmes aimed at preparation for release and prisoner support programmes for the transition between incarceration and release, re-entry and social reintegration'	Right to health: ensuring access to drug services in prisons
Action 16(d): 'Provide appropriate training so that criminal justice and/or prison staff carry out drug demand reduction measures that are based on scientific evidence and are ethical and so that their attitudes are respectful, non-judgemental and non-stigmatizing'	Right to health: ensuring access to drug services in prisons
Action 22(c): 'Ensure that supply reduction measures are carried out in full conformity with the purposes and the principles of the Charter of the United Nations and international law, the three international drug control conventions and, in particular, with full respect for the sovereignty and territorial integrity of States, the principle of non-intervention in the internal affairs of States and all human rights and fundamental freedoms'	Right to be free from torture, cruel, inhuman treatment or punishment, right to life, right to due process and a fair trial, and right to liberty and be free from arbitrary detention
Action 22(e): 'Promote supply reduction measures that take due account of traditional licit uses, where there is historical evidence of such use, as well as environmental protection, in conformity with the United Nations Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances of 1988'	Rights of indigenous people
Action 22(l): 'Remain up to date on scientific studies, data and research on the medicinal and other legitimate uses of plants containing narcotic and psychotropic substances, taking into account the provisions of the three international drug control conventions'	Right to science
Action 28(c): 'Develop prevention and treatment programmes tailored to the specific characteristics of the phenomenon of amphetamine-type stimulants as key elements in any relevant strategy to reduce demand and minimize health risks'	Right to health: ensuring access to harm reduction interventions and evidence-based drug dependence treatment
Action 41(c): 'Ensure that measures to control precursors and amphetamine-type stimulants are carried out in full conformity with the purposes and the principles of the Charter of the United Nations and international law, the international drug control conventions and, in particular, with full respect for the sovereignty and territorial integrity of States, the principle of non-intervention in the internal affairs of States and all human rights and fundamental freedoms'	Right to life, and right to due process and a fair trial

PROMOTING PEACE AND SECURITY

Actions from the 2009 Political Declaration and Plan of Action	Issue of relevance
Action 22(c): 'Ensure that supply reduction measures are carried out in full conformity with the purposes and the principles of the Charter of the United Nations and international law, the three international drug control conventions and, in particular, with full respect for the sovereignty and territorial integrity of States, the principle of non-intervention in the internal affairs of States and all human rights and fundamental freedoms'	Balloon effect & escalating levels of violence, and right to life
Action 24(g): 'Implement strategies to disrupt and dismantle major organizations involved in trafficking in narcotic drugs and psychotropic substances and to address emerging trends'	Balloon effect & escalating levels of violence
Action 36(a): 'Address through concerted action the illegal sale of preparations containing amphetamine-type stimulants via the Internet and the misuse of postal and courier services for smuggling such preparations'	Responses to crypto-drug markets
Action 51(a): 'Establishing new or strengthening existing domestic legislative frameworks to criminalize the laundering of money derived from drug trafficking, precursor diversion and other serious crimes of a transnational nature in order to provide for the prevention, detection, investigation and prosecution of money laundering'	Tackling money-laundering
Action 51(d): 'Promoting effective cooperation in strategies for counter-ing money-laundering and in money-laundering cases'	Tackling money-laundering

ADVANCING DEVELOPMENT

Actions from the 2009 Political Declaration and Plan of Action	Issue of relevance
Action 22(e): ‘Promote supply reduction measures that take due account of traditional licit uses, where there is historical evidence of such use, as well as environmental protection, in conformity with the United Nations Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances of 1988’	Protecting the environment in drug control strategies
Action 43(b): ‘Conduct research to assess the factors leading to the illicit cultivation of drug crops used for the production of narcotic drugs and psychotropic substances’	Analysing factors leading to illegal crop cultivation
Action 43(d): ‘Ensure that States with the necessary expertise, the United Nations Office on Drugs and Crime and other relevant United Nations organizations assist affected States in designing and improving systems to monitor and assess the qualitative and quantitative impact of alternative development and drug crop eradication programmes with respect to the sustainability of illicit crop reduction and socio-economic development; such assessment should include the use of human development indicators that reflect the Millennium Development Goals’	Support and cooperation for alternative development
Action 45(c): ‘Establish, where possible, sustainable alternative development programmes, in particular in drug-producing regions, including those with high levels of poverty, as they are more vulnerable to exploitation by traffickers and more likely to be affected by the illicit cultivation of drug crops and the illicit production of and trafficking in narcotic drugs and psychotropic substances’	Promoting sustainable development in cultivation and trafficking areas
Action 45(d): ‘Consider, where appropriate, including in their national development strategies, integrated and sustainable alternative development programmes, recognizing that poverty and vulnerability are some of the factors behind illicit drug crop cultivation and that poverty eradication is a principal objective of the Millennium Development Goals; and request development organizations and international financial institutions to ensure that alternative development strategies, including, when appropriate, preventive alternative development programmes, are incorporated into poverty reduction strategy papers and country assistance strategies for States affected by the illicit cultivation of crops used for the production of narcotic drugs and psychotropic substances’	Promoting sustainable development in cultivation and trafficking areas
Action 45(f): ‘Ensure that the design and implementation of alternative development programmes, including, when appropriate, a preventive approach, involve all stakeholders, take into account the specific characteristics of the target area and incorporate grass-roots communities in project formulation, implementation and monitoring’	Ensuring collaboration with local communities in illegal crop cultivation areas
Action 47(b): ‘Develop alternative development programmes and eradication measures while fully respecting relevant international instruments, including human rights instruments, and, when designing alternative development interventions, taking into consideration the cultural and social traditions of participating communities’	Ensuring collaboration with local communities in illegal crop cultivation areas
Action 47(c): ‘Ensure that development assistance provided to communities in areas affected by illicit cultivation of crops used for the production of narcotic drugs and psychotropic substances takes into account the overall aims of human rights protection and poverty eradication’	Ensuring that development assistance protects human rights
Action 47(d): ‘Ensure that the implementation of alternative development and preventive alternative development, as appropriate, enhances synergy and trust among the national Government, local administrations and communities in building local ownership’	Ensuring collaboration with local communities in illegal crop cultivation areas

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Action 47(f): ‘Ensure the proper and coordinated sequencing of development interventions when designing alternative development programmes; and, in this connection, the issues of the establishment of agreements and viable partnerships with small producers, favourable climatic conditions, strong political support and adequate market access should be taken into account’	Promoting sustainable development in cultivation and trafficking areas
Action 49(e): ‘Ensure that development partners, affected States and other relevant key development actors examine innovative ways to promote alternative development programmes, including preventive alternative development programmes, where appropriate, that are environmentally friendly’	Protecting the environment in drug control strategies

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