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THE WORLD DRUG REPORT 2024: A FAILED ATTEMPT TO REFRAME THE RIGHT TO HEALTH OF PEOPLE WHO USE DRUGS

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Executive summary

In 2024, the World Drug Report broke its historical silence on the human rights dimension of drug policy with a special chapter on 'Drug use and the right to health'. The present analysis compares this chapter with the April 2024 report on 'Drug use, harm reduction and the right to health' by the UN Special Rapporteur on the Right to Health, Dr. Tlaleng Mofokeng, to assess whether the 2024 edition of the World Drug Report constitutes a genuine move towards integrating a human rights perspective into the global drug control regime.

The answer is negative. The World Drug Report chapter suffers from a critical and unjustifiable methodological flaw; it has been developed without any reference to the standards and recommendations on drugs and the right to health developed over the last 15 years by UN human rights mechanisms, although these have been created precisely to provide Member States with guidance on their human rights obligations. Instead, the chapter is often guided by the UNODC's own policy preferences and desire to manage political tensions at the UN Commission on Narcotic Drugs (CND).

The result is a flawed rendering of the right to health that omits essential elements such as a robust interpretation of harm reduction and support for the decriminalisation of people who use drugs. It also glosses over the undeniable tension between the drug control regime and the right to health, and introduces problematic concepts such as 'the right to health of communities affected by drug use', a notion that is not grounded in human rights standards and risks decentring people who use drugs.

Although the special chapter pitches itself as the basis for a new framework to evaluate States' performance with regards to the right to health, Member States should withhold support for this flawed initiative until it fully integrates the guidance developed by the UN human rights system.

Introduction

The annual launch of the World Drug Report remains an important moment for global drug policy. The 2024 Report contains the habitual impressive array of data and evidence collated by the UN Office on Drugs and Crime (UNODC), which this year is in excess of 200 pages and includes an online database of drug trends. To this, the 2024 edition also adds a short chapter of historical and political significance: a framework to assess the right to health with regards to drug use.

This is the first time that the World Drug Report dedicates a chapter to one of the human rights dimensions of the world drug situation. That the United Nation's own flagship publication on drugs has been able to finally break its historical silence on human rights is an important development. It hints at a future where international drug control bodies might acknowledge the human rights costs of drug policies. It is also a remarkable diplomatic achievement by the group of Member States, led by Switzerland, who called for and provided considerable funding for this special chapter.

It should be no surprise that this breakthrough focuses on the right to health. According to the 2024 World Drug Report, approximately 64 million people worldwide experience some form of drug dependence.[1] Only one in 11 of them have access treatment[2] – a figure that has not improved since 2015. In all regions, women are less likely to access treatment than men.[3] Overdose deaths continue to be near historical highs, significantly driven by the toxic supply crisis of synthetic opioids in North America. In 2022, the risk of acquiring HIV was 14 times higher for people who inject drugs than for the overall adult population.[4] At the same time, the UNODC estimates that in 2022 alone at least 4.5 million people were in contact with the police simply for drug use and possession for personal use.[5]

The first-ever World Drug Report chapter on human rights comes at a time when the long-standing monopoly of the UN drug control regime over international drug policy is no longer tenable. This is largely due to the increasing involvement of UN human rights mechanisms and bodies who, over the last 15 years, have provided a set of standards on how to align drug policy with human rights,[6] emphasising harm reduction and decriminalisation.

The latest contribution from the UN human rights system consists of two high-profile reports on drug policy by the UN Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, Dr. Tlaleng Mofokeng. The first report, published two months before the 2024 World Drug Report, includes a powerful set of recommendations that add an intersectional and decolonial lens to the findings of her predecessors, and culminates with a call to reform the global drug control regime.

Professor David Bewley-Taylor, who passed away in November 2024[7] and to whose memory this report is warmly dedicated, explored for years the different strategies of deflection and reframing employed by the drug control regime to justify its own integrity and survival at a time of 'regime complexity',[8] when other international systems – such as the UN human rights regime – have come to offer 'different solutions' to the so-called 'world drug problem', generating friction, rivalry, and normative contestation.[9]

The question then is whether the first-ever chapter on human rights in the World Drug Report is a good-faith effort to resolve the friction between the drug control and human rights systems, or whether it is simply a deflection manoeuvre – a sleight of hand that seeks to shield the Vienna-based drug control system from criticism by trying to reframe the very notion of the right to health.

The present publication seeks to answer this question through a close reading of the World Drug Report's special chapter and Dr. Mofokeng's April 2024 report on drug use, harm reduction, and the right to health, comparing and contrasting their approaches and recommendations. It will start with a brief review of the existing international standards on the right to health and drug use.

The right to health and drug use: A clear and consistent set of standards

The right to health is a fundamental human right recognised by a broad range of international treaties, as well as regional instruments in Africa, Europe and the Americas.[10] Every State in the world has signed at least one international human rights treaty that recognises the right to health.[11]

The right to health contains freedoms, such as the right to be free from non-consensual medical treatment; and entitlements, such as the right to a system of health protection. All services, goods and facilities must be available, accessible, acceptable and of good quality. The principles of equality and non-discrimination are integral components of the right to health, as is the realisation of other rights and freedoms.[12]

Nobody can enjoy physical and mental health without shelter, nutrition, or income security. As a consequence, the right to health is not limited to medical and healthcare services, but includes the underlying social determinants of health, such as food, housing, social protection and gender equality.[13],[14]

The right to health has historically been the starting point for efforts to align drug policies with human rights.[15] The first UN Special Procedure to take a public position on drug policy was Paul Hunt, then the Special Rapporteur on the right to health, in 2007.[16] The first-ever statement by a UN High Commissioner on Human Rights came in 2009, precisely on the topic of harm reduction.[17] The three thematic reports by the Office of the High Commissioner for Human Rights (OHCHR) on drugs, published in 2015,[18] 2018[19] and 2023,[20] open with a chapter on health-related issues. The human rights treaty body that has been most outspoken on drugs is the Committee on Economic, Social and Cultural Rights (CESCR), which monitors the key international human rights provisions on the right to health.

In the 15 years that have passed since 2007, UN human rights entities and experts have built an ever-growing body of standards and recommendations on drugs and the right to health. While recommendations vary from body to body and from time to time, these are some key common elements:

- Harm reduction interventions are considered 'essential for persons who use drugs',[21] and should be made available to them 'as an integral part of the right to health'.[22] In 2024 alone, the CESCR has provided recommendations to ensure access to harm reduction in at least eight country reviews,[23] and the Committee on the Rights of the Child in two.[24]

- Access to drug dependence treatment is also given a central space. However, drug treatment must be evidence-based and voluntary. Compulsory or coercive treatment poses 'serious challenges to human dignity and rights', is 'ineffective for improving health and public safety outcomes',[25] and is linked to violations of the right to health, the right to be free from torture, and the right to be free from arbitrary detention.[26]

- The criminalisation of drug use and possession for personal use is regarded as a 'major obstacle'[27] to accessing drug services that perpetuate 'many of the major risks associated with drug use'.[28] Member States are consistently recommended to decriminalise drug use and possession for personal use.

- Access to treatment and harm reduction for people in custodial settings is considered a priority, given the prevalence of drug use in prisons. Since 2022, the UN Committee Against Torture has provided recommendations on improving access to drug services in custodial settings in at least seven country reviews,[29] and recommendations on access to harm reduction in two of them.[30]

- The obligation to 'protect' children from illegal drug use is interpreted through a holistic lens. Policies must be based on evidence and grounded in the best interests of children; information must be objective, and 'scare-tactics and misinformation' must be avoided. The Committee on the Rights of the Child has consistently recommended that States provide accessible and 'youth-friendly' harm reduction and drug treatment services.

Box 1. Prevention under international human rights standards

International human rights bodies recognise that States should put in place programmes to prevent or delay the onset of drug use amongst children and youth. They have recommended that States provide information on the nature and harms associated with drug use, as well as awareness-raising campaigns and programmes to build life skills. Indeed, health-related information and education are always integral to the right to health (in particular, but not only with regards to children)[31], as well as more broadly to the right to freedom of expression of everyone.

That said, these recommendations are marked by concerns. In a 2016 report, the then-UN Special Rapporteur on the right to health, Danius Puras, pointed out that 'Scare tactics and misinformation are known to be ineffective, whereas building resilience and trust while focusing on those demonstrating risk-taking behaviours has delivered promising results'.[32] Likewise, he noted that 'Prevention and education programmes that focus on zero tolerance create an environment where adolescents may be less likely to seek information about harms related to use'.[33]

Similarly, the High Commissioner for Human Rights has expressed apprehension around the fact that prevention interventions are sometimes geared at 'complete abstinence', and that their quality is often 'unknown'.[34] The High Commissioner has raised specific concerns about mandatory drug testing in schools, and the impact of fear and punishment-based campaigns on children and youth.[35] The International Guidelines on Human Rights and Drug Policy also highlight the importance of demand reduction measures to prevent drug use, but emphasise that these 'must be based on evidence and compliant with human rights'.[36]

The International Guidelines on Human Rights and Drug Policy are consistent with these themes, clarifying that States' obligations under the right to health include ensuring 'the availability and accessibility of harm reduction services', and that drug treatment services are 'acceptable, delivered in a scientifically sound and medically appropriate manner', and through 'voluntary, informed consent'. On top of that, under the right to health, States are recommended to 'decriminalise the possession, purchase, or cultivation of controlled substances for personal consumption'.[37]

Other developments in international human rights standards have gone in the same direction. The International Commission of Jurists released the '8 March Principles' in 2023, which aim to address 'the detrimental impact of the criminalisation (...) on health, equality and other human rights', and provide strong recommendations for the decriminalisation of drug use and possession.[38] Amnesty International also released its policy on drugs on 26 June 2024, which opens with a chapter on the right to health and includes all the elements outlined above.[39]

Consolidating the human rights approach: The 2024 report of the UN Special Rapporteur on the right to health

Two months before the release of the World Drug Report, the UN Special Rapporteur on the right to health, Dr. Tlaleng Mofokeng, submitted a report to the Human Rights Council entitled 'Drug use, harm reduction, and the right to health',[40] which was followed in September 2024 with a report to the UN General Assembly on 'Harm reduction for sustainable peace and development'.[41]

Dr. Tlaleng Mofokeng is the fourth Special Rapporteur in a row to dedicate attention to the impacts of drug policies on the right to health out of their own initiative (human rights special procedures are independent experts and they set up their own agenda and workplan). Paul Hunt was holding the position of UN Special Rapporteur on the right to health when he famously declared in 2008 that the international human rights and drug control systems had to stop behaving as if they existed in 'parallel universes'.[42] Two years later, his successor

Anand Grover became the first UN human rights expert to dedicate a thematic report to drug policy.[43] And, in turn, his successor Danius Puras led an open letter on the occasion of the 2016 UNGASS,[44] authored an influential chapter on adolescents and drug use,[45] and released a public statement on the right to health of people who use drugs at the outbreak of the COVID-19 pandemic.[46]

Dr. Mofokeng's report is thus first and foremost a continuation document that builds on the recommendations developed by former Special Rapporteurs on the right to health. But Dr. Mofokeng also proposes a series of new recommendations, which must be taken stock of.

The tension between human rights and the UN drug control regime

The first line of Dr. Mofokeng's report is possibly its most important breakthrough. It states the simple reality that the use of psychoactive substances is a permanent feature of human experience; drugs are used for medicinal and therapeutic purposes, for sure, but also for pleasure – this is maybe the first time that this acknowledgement appears in a UN document related to drugs. This represents a radical departure from the worldview at the heart of the UN drug conventions which present drug 'addiction' as an 'evil'[47] and seek to eradicate global drug markets.

The Special Rapporteur then develops an explicit critique of the international drug control regime, highlighting its neocolonial origins and its harmful consequences, chief of which being that it has 'propelled'[48] a punitive approach that has been devastating for the enjoyment of the right to health. States should therefore 'revise the international legal framework on drugs' to align it with human rights and 'operationalise' the right to health.[49]

This call for change is far from an outlier. Already in 2010, the then Special Rapporteur Anand Grover wrote that 'The ineffectiveness of the current international drug control system must be understood, and reform undertaken at all policymaking levels'.[50] More recently, and the UN High Commissioner for Human Rights has repeatedly called for 'transformative change' in global drug policy.[51]

The recommendation to change an international legal framework is not uncommon in the human rights system. The CESCR itself has noted that the International Covenant on Economic, Social and Cultural Rights 'requires States parties to contribute to creating an international environment that enables the fulfilment of the Covenant rights'[52], including through 'diplomatic and foreign relations measures, to promote and help create such an environment'.[53] The CESCR has also found that States 'should harmonise the fulfilment of their obligations under the international drug control regime with their obligations to respect, protect and fulfil the right to participate in and to enjoy the benefits of scientific progress and its applications'.[54] This applies when 'negotiating international agreements' and 'when participating as members of international organisations'.[55] International law, such as the international drug control conventions, should be – and in fact is – ever evolving.

Recognising the harms of the punitive system from an intersectional perspective

When laying down the priorities of her mandate,[56] Dr. Mofokeng explained that she would take an anti-racist, decolonial and intersectional approach to the right to health. This is borne out in her report, which features a clear-eyed recognition of the 'profoundly negative' impact of drug policies on people that 'already experience intersecting layers of discrimination', and acknowledges that the different ways in which people may be involved with drug use or drug supply are mediated by 'social, political, commercial, and legal determinants' such as wealth, status, and existing systems of discrimination and power asymmetries, such as racism.[57]

In doing so, the Special Rapporteur is following the position of a broad range of UN human rights mechanisms who have now been recognising for years that 'The 'war on drugs' may be understood to a significant extent as a war on people. Its impact has been greatest on those who live in poverty, and it frequently overlaps with discrimination directed at marginalised groups, minorities and Indigenous People', particularly for people of African descent.[58] To these categories, the Special Rapporteur also adds workers and migrants.

Box 2. Responsible regulation as part of a human rights-based approach to drugs

One of the key recommendations in Dr. Mofokeng's report is that States should 'Move towards regulatory approaches that put the protection of people's health and other human rights front and centre'.[59] Whilst this recommendation may be shocking in the eyes of actors within the global drug control regime, it is entirely consistent with the Special Rapporteur's critique of the drug conventions, and in fact falls squarely within the tradition of the special mandate on the right to health.

Already in 2010, the holder of the special mandate on the right to health, Anand Grover, recommended that States 'Consider the creation of an alternative drug regulatory framework', which according to his proposal would be inspired by the Framework Convention on Tobacco Control.[60] His successor as Special Rapporteur, Dainius Puras, also authored an article describing drug prohibition as a 'failed policy model' with 'devastating effects on human rights and public health worldwide'.[61]

Since then, calls for legal regulation as a human rights approach have extended to the High Commissioner for Human Rights, who in 2023 recommended that States move to the 'responsible regulation'[62] of drugs, and has repeatedly demanded 'transformative change' in the global drug control regime. It remains to be seen whether other human rights mechanisms will follow this lead and endorse legal regulation as a human rights-based alternative to the prohibitionist paradigm.

Dr. Mofokeng describes the criminalisation of drug use and possession for personal use as an 'extreme'[63] policy option, and a driver of human rights violations – on liberty, on privacy and on the right to be free from torture – that are interlinked and harmful to the enjoyment of the right to health. But the recognition of the harms of the criminal legal system does not stop with the criminalisation of people who use drugs. Throughout the report, there is an interest in the effects of criminalisation on people who 'produce and distribute' drugs and those who are 'charged with a drug offence'.[64] This position is in tension with the 1988 Convention Against Illicit Traffic in Narcotic Drugs, which precisely requires the criminalisation of people who are involved in supply activities.

An expansive approach to harm reduction

In line with the recommendations of her predecessors, Dr. Mofokeng recognises harm reduction as a critical element of the right to health. She goes on to provide a capacious and non-exhaustive list of harm reduction interventions that goes well beyond the certainly important, but static and limited package of harm reduction services that was endorsed by the UNODC, the World Health Organization (WHO) and the Joint United Nations Programme on HIV and AIDS (UNAIDS) in 2009 and revised 2012,[65] and which revolve around injecting opioid use.

Some of the most welcome innovations include a strong recommendation for drug consumption rooms and drug checking interventions, as well as access to housing, employment, education and social protection for people who use drugs, all of which are considered elements of a holistic harm reduction approach. As we shall now see, the framework on the right to health proposed by the World Drug Report's special chapter takes a drastically narrower view.

The World Drug Report special chapter on the right to health: The good, the bad, and the ugly

At only 9 pages, the World Drug Report special chapter on the right to health is a short document, but of political and historical significance. For years, the World Drug Report has failed to provide data

or evidence on the human rights impact of drug policies – or even to mention human rights at all.[66] 2024 will be known as the year when the UN flagship publication on drugs finally began to engage with the human rights dimension of the world drug situation.

The chapter was funded by a small group of Member States comprising the Netherlands, Norway, Sweden and Switzerland. It can be presumed that their intention was to use it as an entry point for a conversation on human rights in Vienna. As explained above, the right to health has historically been the gateway to broader discussions on drug policy and human rights.

With such high expectations set on it, the chapter aims to offer a framework to assess the right to health with regards to drug use, structured in five 'building blocks' or dimensions. It presents this framework as a first step towards developing a series of new indicators that could be used to bring 'scrutiny' into how Member States are 'promoting the right to health in relation to drug use'.[67]

The aim of this section is to find out, through a close reading of the report and contrasting it against the report of the Special Rapporteur on the right to health, whether the chapter has achieved its stated goal. The conclusion is a resounding no.

The main reason behind this failure is methodological. The framework proposed by the UNODC has been developed with no reference to the standards and recommendations on the right to health built by UN human rights mechanisms over the past 15 years. This is a deep flaw, and it comes at great costs. It exacerbates the fragmentation of the UN system on drug-related matters, reinforcing the historical isolation of the Vienna-based drug control regime. More importantly, it offers an incomplete and often problematic rendering of the right to health that differs from the applicable international standards on key issues such as harm reduction and decriminalisation. If implemented, it would be detrimental to the rights of people who use drugs.

UN human rights mechanisms exist for a reason. They have a legal and political mandate to provide authoritative guidance on human rights, a guidance that should be followed by UN entities themselves. Human rights treaty bodies such as the CESCR are entrusted by Member States with interpreting and monitoring the implementation of human rights treaties. It is unjustifiable that none of its dozens of recommendations on the right to health and drug use are quoted in the World Drug Report. Similarly, it is inexplicable to find no reference to the mere existence of the special mandate on the right to health, although it was established by the Human Rights Council to report and advise on exactly that matter, and it has provided substantive recommendations on drug use since 2007.

In contrast, the UNODC – and by extension the World Drug Report – has neither the mandate, nor the legitimacy or the capacity to elaborate its own interpretations of human rights. It should seek coherence and harmonisation with the rest of the UN system, for instance through coordination mechanisms like the Task Team to Implement the UN system Common Position on Drugs, which is led by the UNODC itself. Given these limitations, investing in further developing the UNODC's framework, or in elaborating new indicators, would be counterproductive and harmful.

The good: (Partial) alignment with human rights standards

The framework proposed in the chapter contains a number of elements that are important and are – at least to some degree – aligned with the international standards on the right to health as developed by the UN human rights system.

It is positive that the first 'building block' of the framework concerns the global dearth and inequality in access to controlled medicines for pain management, palliative care and agonist drug treatment, which constitute an essential component of the right to health.[68] This reflects the now widespread and largely uncontroversial focus on access to medicines within the UNODC and at the CND – indeed one of the issues in which the battered Vienna spirit has taken refuge.[69]

However, the World Drug Report's special chapter fails to mention the drivers behind this phenomenon, and proposes no policy or recommendations to address it. In contrast, Dr. Mofokeng has used her report to urge Member States to 'ensure that drug control policies do not impede access to essential medicines',[70] and has emphasised the role of the pharmaceutical industry and the commercial determinants of health in restricting access.[71]

Likewise, the High Commissioner for Human Rights has pointed out that 'Lack of training of the health workforce, unduly restrictive regulations, and "fear of addiction" are the main impediments'[72] to increased and more equal access. In Vienna, the International Narcotics Control Board (INCB) has also gestured to onerous regulations, prices that are too high for low and middle-income countries, and the need for educational training and awareness-raising.[73]

Prevention interventions, particularly aimed at children and youth, are separated from all other health and social interventions and are given priority as the second 'building block' of the framework proposed by the UNODC. There is a political convenience to this, as prevention is a major fundraising priority for the UNODC at the present time. Nonetheless, the underlying recommendations are generally aligned with international human rights standards. It is positive that prevention programmes are recommended to address the 'social determinants of health and attend to vulnerabilities (such as poverty, unstable housing and so on)',[74] and that they are 'ethical and culturally appropriate'.[75]

However, the special chapter fails to mention the many recommendations on youth-friendly harm reduction provided over the years by the Committee on the Rights of the Child, and the overall tone with regards children and youth is paternalistic, and could lead to scaremongering. As the Paradigma Coalition explores in Box 3, this problem is not unique to Vienna.

Box 3. Beyond vulnerability: Reimagining discussions on youth and drugs in UN reports

Young people today stand at the crossroads of policy and lived reality, particularly in the realm of drug use. They navigate complex social and personal landscapes, but their perspectives are often sidelined in major policy frameworks. Narratives of youth vulnerability intersect with the urgent need for rights-based approaches.

While UN drug policy documents developed in Vienna and Geneva acknowledge the importance of addressing youth issues in drug policy, they fall short in fully capturing the unique experiences of marginalised youth, particularly in regions with high criminalisation rates. By framing children and adolescents as vulnerable populations needing protection rather than as active stakeholders capable of contributing to policy discussions, they overlook the potential for young people to engage meaningfully in conversations about drug policy reform, a concept supported by research on youth participation in policy-making.[76]

This year's World Drug Report is no exception, even though the traditionally conservative UNODC is beginning to acknowledge the complexities faced by youth who use drugs. It is positive, for instance, to see mentions of obstacles in accessing treatment, the need for age and gender-appropriate drug education and even a recognition of the Convention on the Rights of the Child, emphasising that 'the best interests of the child are a paramount consideration in all cases',[77] particularly in instances where children have parents who use drugs. Aligned with guidance from the UN Committee on the Rights of the Child (CRC),[78] the World Drug Report recognises that drug use alone does not warrant the removal of parental rights.

While the World Drug Report mentions youth more frequently, achieving positive health outcomes for children and young people seems to be acknowledged primarily through the prevention of drug use initiation, particularly through prevention programmes offered by 'trained professionals'. Using such a denominator as a criterion for success, the UNODC overlooks the importance of peer-led interventions, which have been shown to be effective in youth drug education and harm reduction.[79]

Dr. Mofokeng's report, in contrast, employs a much stronger rights-based approach, as it explicitly addresses concerns about mandatory drug testing in schools and its implications for

children's rights, highlighting potential violations of bodily integrity and privacy. It also refers to 'children' along with a number of other demographics that are discriminated against and disproportionately affected by drug laws and health regimes, although even that report fails to mention the distinct needs and challenges faced by teenagers and young adults.

Yet, neither document sufficiently addresses the issue of age discrimination as a barrier to accessing healthcare services for young people, nor do they acknowledge young people who are arbitrarily detained for drug offences. In both documents, there is also a lack of specific harm reduction strategies tailored for young people. Furthermore, the World Drug Report's frequent use of 'age-appropriate' language is concerning as research has shown that overly restrictive age-based criteria can limit young people's access to health services.[80]

Both reports call for improved drug education for youth, yet they fall short of recommending young people's empowerment through factual information about drug use and its consequences, while equipping them with skills to make informed decisions about their health and ensure their access to justice. Peer-led programmes should also have been emphasized as an approach that fosters a sense of community, support and belonging.

This text box is a contribution by Paradigma, a global coalition of youth-led organisations working towards a new paradigm in drug policy.[81]

The series of recommendations on access to drug services for people deprived of liberty are positive, as is the recognition of the harmful impact of the 'high rates of incarceration for drug use and possession for personal use'. These are but a small part of the third 'building block' of the UNODC's proposed framework, which concerns drug treatment and care services. But they are aligned with the findings of the UN human right system, including the fact that people in prison should have access to treatment and harm reduction services equivalent to those available in the community.[82]

The paragraph that recognises accessibility of information as an essential component of the right to health, at the closing the third dimension, is likewise commendable, particularly considering the prominent role of scare tactics and misinformation in the context of drug policies and practices.

Last but not least, it is positive that the fifth and last dimension of the proposed framework concerns the meaningful participation of people who use drugs, communities and local civil society in 'health-related decisions' connected to drug use. This, however, falls far short of Dr. Mofokeng's call to 'Ensure that peer-led initiatives remain at the forefront', and that they have 'political and policy support and stable and sufficient resourcing and funding'.[83]

The bad: An incomplete rendering of the right to health

The framework proposed by the UNODC minimises or excludes a series of elements that have been considered central to the right to health by a large number of human rights bodies and experts – first and foremost, harm reduction and decriminalisation. This decision appears to hinge on political convenience for the UNODC itself, alongside concerns about what subjects remain (unjustifiably) controversial in Vienna, rather than on a genuine assessment of what contributes to the protection of the right to health.

Minimising the role of harm reduction in the right to health

The main missing element of the UNODC's framework is, of course, the term 'harm reduction'. Harm reduction has been considered 'essential for the protection of the right to health of people who use drugs'[84] by the three last holders of the special mandate on the right to health. The CESCR has also provided scores of recommendations on expanding access to harm reduction services in dozens of country reviews, as has the CRC. Other mechanisms such as the UN Working Group on Arbitrary Detention or the UN Committee on the Elimination

of Discrimination Against Women have also provided recommendations on harm reduction.

And yet, the World Drug Report is unable to use the term 'harm reduction' in the proposed framework – mirroring the UNODC's similar reticence to use that term in most of its public documents. Instead, the special chapter resorts to the paraphrase 'effective measures aimed at preventing and reducing the adverse public health and social consequences of drug use'.

This decision is clearly political. 'Harm reduction' is the terminology that has been used for decades on a routine basis by practitioners, public officials, civil society and people who use drugs alike. It is endorsed by the UN System Common Position on drugs, the UN General Assembly, the Human Rights Council, the OHCHR, the World Health Assembly, the WHO, UNAIDS – and even the UNODC's own HIV/AIDS Section. However, at the CND in Vienna, a very small but vocal alliance of Member States still refuses to accept these two words, a position that in March 2024 led to one of the first votes on a CND resolution in recent history.[85] It is telling that the UNODC continues to yield to these resistant countries (only Russia and China voted against the aforementioned resolution), and that its proposed framework for the right to health would look to political and diplomatic considerations instead of international standards and guidance from across the UN.

It is even more concerning that the harm reduction interventions included in the chapter are explicitly limited to the package of interventions elaborated by the WHO, UNAIDS and UNODC in 2009 and revised in 2012. Whilst this normative guidance remains valuable in the context of injecting drug use and HIV, it has since been updated by the WHO in 2022.[86] Limiting harm reduction to a set of HIV-driven services is in contrast with the description of harm reduction proposed by Dr. Mofokeng in her report, which is explicitly non-exhaustive and covers a 'wide range of policies, programmes and practices' aimed at minimising the negative health, social and legal impacts of drug use and drug laws.

Under the framework proposed by the UNODC, the right to health has no place for harm reduction interventions that address the needs of people who use drugs other than opioids, or by means other than injection – that is, most people who use drugs in the world. Furthermore, the chapter ignores harm reduction interventions such as drug consumption rooms and drug checking, both of which are recommended by Dr. Mofokeng, and are precisely designed to address the risks posed by the unregulated supply of synthetic drugs that is now claiming tens of thousands of lives every year, particularly but not only in North America. Instead, the UNODC relies on its own outdated but politically safe documents, rather than on what is central to protecting the health of people who use drugs.[87]

Turning a blind eye on criminalisation and the impacts of the punitive paradigm

The criminalisation of drug use and possession for personal use has been identified as a major barrier to the enjoyment of the right to health of people who use drugs by the UN human rights system as early as 2010.[88] Growing evidence demonstrates that it is associated with reduced access to health interventions and worse health outcomes.[89] As the '8 March Principles' explain, the criminalisation of people who use drugs 'contributes to a broad range of human rights violations',[90] and there is overwhelming evidence of its disproportionate impact on people who are black, brown or Indigenous, against women and the LGBTQI+ community, and against people living in poverty.[91]

The framework presented by the UNODC chapter cannot hide away from this reality. At the opening of the chapter, the 'fear or threat of legal sanctions for people who use drugs'[92] is presented as a constraint on the enjoyment of the right to health, as are 'drug-related laws and regulations'.[93] However, this is as far as the chapter is willing to go. Not only does it seek to avoid the terminology and concept of decriminalisation, but it even shies away from including any finding on, or recommendation for, the promotion of alternatives to punishment or incarceration for people who use drugs. This stands in stark contrast with the full-hearted endorsement of decriminalisation by the UN System Common Position on drugs and by a plethora of UN bodies and experts.[94]

The chapter does recognise, in passing, the harmful impacts of punitive interventions on the right to health. 'High rates of incarceration for drug use and possession for personal use offences' as well as prison overcrowding, are mentioned as exacerbating health risks for people who use drugs in prisons.

In the same paragraph, it is noted that 'Research has shown that the policing of people who use treatment and care services discourages them from accessing treatment'. But these are the only two references in the whole of the UNODC's proposed framework for the assessment of the right to health.

The Special Rapporteur on the right to health has taken the opposite approach. Criminalisation, she clarifies, as well as 'overuse of incarceration, arbitrary deprivation of life, unnecessary use of lethal force in drug enforcement and application of the death penalty as punishment in the name of public health',[95] have had negative impacts on public health. Violations of privacy and confidentiality dissuade people from accessing drug services, particularly when there is involvement by law enforcement agencies.[96] And, critically 'Being charged with a drug-related offence is a stigma that can last a lifetime', with devastating impacts on a broad range of rights.

Here again emerges the cost of avoiding a genuine human rights approach. The UNODC remains unwilling to acknowledge the connection between the right to health and the overwhelming punitive architecture that is propelled by the international drug control regime itself. Police brutality, surveillance, and incarceration – not to mention capital punishment or extrajudicial killings – are intimately related to violations of the right to health.

The ugly: A selective framing of drug use and people who use drugs

One of the most troubling elements of the framework proposed by the UNODC is the selective introduction of concepts that have so far not been developed within the standards relating to the right to health by the UN human rights system, and that seek to legitimise the international drug control regime.

Box 4. Wilfully blind at the human rights implications of coerced treatment

The World Drug Report special chapter recognises that people who use drugs have the rights to bodily autonomy and informed consent, and that this applies to drug treatment interventions, including 'the right to withdraw at any time'.[97] In a welcome move, the chapter also recognises the prevalence of 'unethical standards of care in drug treatment and care', including treatment that is 'involuntary or compulsory or is only aimed at abstinence'.[98]

Compulsory treatment is one of the very few punitive interventions that the chapter calls out, possibly because there is a strong precedent in prior statements by the UNODC together with other UN agencies.[99] However, the chapter takes pain to distinguish it from coercive treatment, a prevalent State practice under which people who use drugs are made to 'choose' between treatment and punishment, including in some cases imprisonment.

Regrettably, the UNODC refuses to voice any concern over coercive treatment. In cases of coercive treatment, it argues, 'there is a choice to refuse it even if options are limited',[100] and even if punishment and incarceration may be the consequence of such choice. At any rate, the UNODC continues, there is often a measure of 'pressure and persuasion' in any form of voluntary treatment. This nonchalance stands in clear tension with the findings of the High Commissioner for Human Rights[101] and the UN Working Group on Arbitrary Detention.[102] The latter in particular has concluded in 2021 that 'the measure of coercion involved in such a choice is too great and is an unacceptable infringement on the right to choose one's treatment freely, to refuse treatment or to discontinue it at any time'.

The most significant innovation is the notion of rights holders affected by a person's drug use – particularly children, families and communities at large. This concept is used systematically throughout the chapter, starting in the introduction itself, which makes clear that the framework seeks to address the right to health of people who use drugs, as well as 'their children, other family members and communities affected by drug use'.

'Children exposed to drug use'

The report is particularly concerned by the situation of 'children exposed to drug use'. Now, there is significant and growing research on the possible impacts of parental drug use problems on children, particularly regarding mothers who are the main caregivers.[103] It is an important issue, and one that deserves more attention. However, existing research clarifies that the sole act of using drugs is not harmful to children and should entail no limitation on rights, and places equal attention on the impacts of stigmatising and criminalising laws and practices on parents and their children.[104] In contrast, the framework proposed by the UNODC focuses only on the potential harms of drug use, and excludes the harms driven by criminalisation.

In fact, it can be argued that the very terminology of 'children exposed to drug use' is problematic. The issue is not that children may be near their parent's drug use, but rather that some children can experience harms associated with their parents' drug use. These harms are mediated by the social, political, commercial and legal determinants of health which States must seek to address, rather than focus on drug use only.

Furthermore, the portrayal of children primarily as potential victims of their parents' drug use and as targets for prevention interventions, rather than as individuals entitled to enjoy all dimensions of the right to health including youth-friendly drug treatment and harm reduction, reflects a limited and politicised perspective on children's rights. This approach does not fully align with the recommendations of the UN human rights system and raises questions about the UNODC's commitment to prioritising the best interests of the child as a paramount consideration.

Experts have recently proposed the notion of 'child-centered harm reduction', which comprises studies and practices that seek to reduce 'the health and social harms to those under the age of 18 due to their own drug use, parental or family drug use, or related laws and policies'.[105] This framework takes into consideration the impacts of criminalisation and, more broadly, of drug and family laws.[106] The most recent research on children whose parents experience drug use problems, released by the Pompidou Group in 2021, has found that 'Human rights violations against people who use drugs have a cascade effect on their children',[107] and it has recommended that States 'scrutinise, assess and amend the negative impacts of criminalising and stigmatising policies that affect people who use drugs and their dependents, particularly children and the elderly'.[108] It is unfortunate that this dimension is absent from the World Drug Report.

The right to health of communities affected by drug use

The World Drug Report makes the point of highlighting 'communities' affected by drug use amongst the key rights holders within its framework on the right to health and drug use. This is emphasised in both the special chapter and in the World Drug Report booklet containing key findings and recommendations.[109] By this, the UNODC refers to third persons, beyond children and family members, whose right to health is negatively impacted by someone else's drug use.

Indeed, drug use may have secondary impacts on third persons that can constitute legitimate concerns for policy makers. These could include disruptions to public order, public nuisance, or activities that endanger other people such as impaired driving, to put a few examples. However, the conceptual move proposed by the UNODC is highly problematic in several respects.

First of all, the notion of a community's 'right to health' being negatively impacted by drug use has no legal basis in international human rights standards. The CESCR's general comment on the right to health does not address the rights of communities or third parties, nor do the human rights mechanisms' recommendations on drugs and health. Current human rights standards on drugs do not view drug use as something that infringes on the rights of others or as an activity from which communities need protection. Instead, UN human

rights bodies recognise people who use drugs as the primary group whose rights are at risk.

Furthermore, the UNODC does not make any effort to provide specific examples of how the right to health of a third person or a community would be in practice impacted by drug use, leaving this to speculation. In reality, the secondary impacts of drug use – even if they could be included within the remit of the right to health – are often linked to poverty, exclusion and marginalisation, rather than drug use itself. Policies should focus on these underlying issues rather than simply on proximity to drug use.

And even when there is a potential harm to third persons, it is disingenuous to present 'communities' as primary rights holders in discussions of health and drug use at the same level as people who use drugs, as if the quality and quantity of harms experienced as a result of the world drug situation – and particularly State responses – were comparable at any level. What is worse, this framing suggests that people who use drugs are potential threats to others solely because of their drug use, thus feeding stigmatising stereotypes. This is reinforced by the chapter's appeal to the notion of people's duties 'to other individuals or to the community', when describing the applicable elements of the right to health.

Ultimately these formulations cast 'drug use' as an inherently harmful activity against which States would need to take protective measures to uphold human rights. This is something that will sound familiar to those acquainted with the 1961 Single Convention on Narcotic Drugs, which committed States to 'combat and prevent' the 'serious evil' of drug 'addiction', considering its 'social and economic danger to mankind'.

Box 5. The World Drug Report fails to walk the talk on stigma

Condemnations of stigma and discrimination against people who use drugs can now be found in CND resolutions,[110] and the need to address the stigma associated with drug use is of course incorporated into a large array of international human rights standards and UN documents. This is a welcome development – yet walking the talk on stigma and discrimination seems complicated for institutions whose sole purpose is to combat drugs. The World Drug Report special chapter is a clear example of this.

Positively, the fourth dimension of the right to health framework proposed by the UNODC is entirely concerned with the harms of 'stigma and discrimination against people who use drugs'. These are recognised as being 'pervasive' and representing a 'major barrier to accessing health care',[111] particularly by women, 'minority groups, and other population groups'.

However, the framing of the chapter is often stigmatising. This is clearest in the section on 'children exposed to drug use'. The fine print of the section indicates that 'drug use disorders do not, of themselves, constitute abuse or neglect', and should be 'no reason to notify authorities'. However, the headline of the section, with its reference to drug use as the ultimately harmful activity, does not reflect this nuance. The UNODC would do well to be more cautious when giving the impression that drug use is in itself conducive to the neglect or harm towards children.

The special chapter also fails to point to the role of State policies in driving such stigma. Laws that criminalise, punish or coerce people who use drugs into treatment have an obvious stigmatising effect, as they send the message that people who use drugs are either law breakers or sick people deprived of agency. Dr. Mofokeng's report is clear about this when it states that 'The criminalization of drug use also aggravates the stigmatization of and discrimination against people who use drugs'.[112] At the same time, if stigma is harmful, States should bear the duty to promote non-stigmatising attitudes, as Dr. Mofokeng[113] and Amnesty International[114] have both highlighted. This important point is entirely missing in the World Drug Report.

A failed defence of the global drug control regime

Ultimately, the special chapter must be understood as a defence of the compatibility of the drug control regime with human rights, at a time when an increasing number of actors are questioning it.[115] This becomes obvious in the very introduction of the chapter, when the UNODC states that the right to health is consistent 'with the very general objective of the international drug conventions', and that it 'does not preclude or contradict the goals of reducing illicit supply and demand of drugs, or with the functioning of the international drug control regime'.

This is in line with the position of the INCB, which has claimed that 'there is no conflict between the international drug conventions and other international human rights instruments'. In fact, according to the Board, the drug conventions should be seen as an integral part of a broader human rights framework. 'The three conventions, as *lex specialis*, make more specific the way that human rights must be observed in the area of drug control' and 'the most effective way to promote human rights in the field of drug control is to limit the use of drugs to medical and scientific purposes'.[116]

These conclusions contrast dramatically with the recommendations of the Special Rapporteur on the right to health, who unequivocally calls for a review of 'the international legal framework on drug control to best align with international human rights norms and standards, harm reduction approaches and the operationalization of the right to health approach'.

If the framework proposed by the UNODC seeks to show that the right to health is compatible with the drug control regime, it proves exactly the opposite. By presenting an interpretation of the right to health tailored to the needs of the UNODC, it reveals what has had to be to be cut out, ignored, misrepresented, or glossed over. The first element to be discarded is the entire body of standards on human rights and drug policy developed by the UN's own human rights system. After that comes the exclusion of essential elements of the right to health of people who use drugs, including harm reduction for all people who use drugs, decriminalisation, and a true commitment to voluntary treatment.

Conclusion: A system in crisis needs a genuine human rights-based approach

The 2024 World Drug Report marks the first time that this publication addresses explicitly a human rights dimension of drug policy. This is, in itself, a historical shift. The UNODC's special chapter on the right to health therefore serves to test whether the global drug control regime is finally able to break the walls between the historic silo between human rights and drug policy, and engage meaningfully with the human rights impacts of drug policy.

Regrettably, the UNODC fails to pass this test. This is due to a deep methodological flaw. While the World Drug Report aims to present a new framework to assess the right to health with regards to drugs, it has been written in complete disregard for the rich and extensive set of standards built by the UN's own human rights system, which has been established precisely with the purpose of providing guidance and recommendations on how to implement States' human rights obligations. The end result is a highly problematic and incomplete conceptualisation of the right to health that excludes key elements essential to the health and dignity of people who use drugs.

Instead of building bridges and seeking to solve discrepancies between the human rights and the drug control regimes, the chapter makes selective use of certain standards to justify the UNODC's current policies and hinder system coherence.

The special chapter pitches itself as the basis for a new framework that the UNODC would develop to evaluate States' performance with regards to the right to health, including by establishing a new set of indicators. Considering our analysis, Member States should not go down the path of implementing (or funding) this new framework. Instead, any consideration of new indicators in this area should be made on the basis of the guidance provided by the UN human rights system, including the latest report and recommendations of the UN Special Rapporteur on the right to health, as well as the indicators that have already been developed by civil society, including in the Global State of Harm Reduction[117] and the Global Drug Policy Index.[118]

Ultimately, the 2024 World Drug Report's special chapter on the right to health is yet another example of the UNODC's isolation from, and refusal to seek coherence with, the rest of the UN system – in large part because it prioritised avoiding an exacerbation of political tensions in Vienna. It is further evidence of the very fact it seeks to disprove, namely the friction between the drug control and human rights regimes. For the UNODC to break away from its growing irrelevance, it needs to engage in good faith with the UN human rights system. The 2024 World Drug Report shows that we are still far away from that moment.

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IDPC dedicates this report to Professor Dave Bewley-Taylor who passed away in November 2024. Between 2006 and 2023, Dave had been the primary author of IDPC's yearly analyses of the World Drug Report and other landmark publications. As a co-founder of IDPC, Dave's impact and legacy within the organisation and across the drug policy reform sector is immeasurable and will continue to inspire our research and advocacy for many years to come.

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

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This report compares the World Drug Report's special chapter on the right to health with the report on harm reduction of the UN Special Rapporteur on the Right to Health, to assess whether the 2024 edition of the World Drug Report constitutes a genuine move towards integrating a human rights perspective into the global drug control regime.

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