



Empowered lives.
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Development Dimensions of Drug Policy: Innovative Approaches

June 2019

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HIV, HEALTH AND DEVELOPMENT



Cover: **Selling coca leaves in the market, Cochabamba, Bolivia.**

Photo: Douglas Anderson.

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Women incarcerated in Buen Pastor Prison, Costa Rica.

Photo: Jessamine Bartley-Matthews/WOLA.



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The 2030 Agenda for Sustainable Development (2030 Agenda) and the 17 Sustainable Development Goals (SDGs) contain a number of important commitments made by 193 UN Member States. These include ending poverty and hunger, ensuring health and well-being, fighting gender and societal inequality, protecting the environment and promoting peaceful and inclusive societies, as well as the pledge to leave no one behind. In the Outcome Document of the Special Session of the United Nations General Assembly on the World Drug Problem (UNGASS 2016), UN Member States acknowledged that efforts to achieve the global goals and to address the ‘world drug problem’ were ‘complementary and mutually reinforcing’.¹

Illicit drug markets and efforts to address them cut across almost every one of the SDGs and the commitment to leave no one behind. Ensuring that drug policy and the 2030 Agenda are coherent is essential to the achievement of the commitments made by UN Member States.

The United Nations Development Programme’s (UNDP’s) Strategic Plan 2018–2021² and its HIV, Health and Development Strategy 2016–2021³ highlight the role UNDP can play in supporting governments to attain the SDGs. This includes addressing the structural barriers and discriminatory laws, policies and practices that marginalize vulnerable population groups, including people who use drugs. In June 2015, UNDP released a discussion paper reviewing the impacts of drug enforcement policies on public health, safety and security, and human rights of poor and marginalized populations. These include indigenous peoples, people who use drugs, including for drug dependence or pain treatment, poor farmers who cultivate illicit drug crops, and people who live in the communities where drugs are trafficked or sold.⁴ In April 2016, UNDP published a report describing initiatives undertaken by a range of countries and by civil society to address the harmful consequences of certain drug policy approaches, particularly for the poor and marginalized individuals and communities mentioned above.⁵

In November 2018, the United Nations system adopted a common position committing to support Member States in developing and implementing ‘truly balanced, comprehensive, integrated, evidence-based, human rights-based, development-oriented and sustainable responses to the world drug problem, within the framework of the 2030 Agenda for Sustainable Development’.⁶ In March 2019, the UN system coordination Task Team, of which UNDP is a member, issued its first report. The common position and the Task Team report echo the UNGASS 2016 Outcome Document position that the international drug control conventions are sufficiently flexible to allow countries, consistent with international law, to design and implement national drug policies according to their priorities and needs. The publication of the Task Team report coincided with the launch of the International Guidelines on Human Rights and Drug Policy, co-sponsored by UNDP, the World Health Organization, the Joint United Nations Programme on HIV/AIDS and the International Centre on Human Rights and Drug Policy. With 27

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1. UN General Assembly, *Resolution S-30/1: Our Joint Commitment to Effectively Addressing and Countering the World Drug Problem*, UN Doc. A/RES/S-30/1 (2016) [hereinafter 2016 UNGASS Outcome Document], annex, preamble.
 2. Executive Board of the United Nations Development Programme, the United Nations Population Fund and the United Nations Office for Project Services, *UNDP Strategic Plan, 2018–2021*, UN Doc. DP/2017/38 (2018).
 3. United Nations Development Programme, *HIV, Health and Development Strategy 2016–2021: Connecting the Dots* (2016).
 4. United Nations Development Programme, *Addressing the Development Dimensions of Drug Policy* (2015).
 5. Ibid.; United Nations Development Programme, *Reflections on Drug Policy and Its Impact on Human Development: Innovative Approaches* (2016).
 6. United Nations System Chief Executives Board for Coordination, *Summary of Deliberations*, UN Doc. CEB/2018/2 (2019), annex 1.

principles capturing the expansive human experience of drug control, the Guidelines are a critical resource to advance the common position at the international, regional and country levels.⁷

This discussion paper reviews some of the ways that countries throughout the world continue to use the flexibility available in the drug conventions to promote inclusive development, human rights and public health-driven, evidence-informed approaches. In this context, this discussion paper presents innovative steps taken by UN Member States in implementing commitments undertaken at the 2016 UNGASS, and with respect to the 2030 Agenda.

7. International Centre on Human Rights and Drug Policy, United Nations Development Programme, UNAIDS and World Health Organization, *International Guidelines on Human Rights and Drug Policy* (2019).



Farmers collecting opium seeds after the harvest, Loi'em Township, Myanmar.
Photo: Tom Kramer.

Towards sustainable livelihoods

Drug cultivation in many areas is driven by lack of secure land rights and lack of access to arable land, among other factors.⁸ Conversely, having secure land rights and access to arable land facilitates access to credit and income and, in turn, the capacity to transition to other crops and to earn a sustainable livelihood.⁹ Women in many crop-cultivating areas can obtain legal land titles only through husbands or male relatives.¹⁰ As a result, women are disproportionately disadvantaged in gaining access to land and, in turn, securing credit and earning income.

The UNGASS 2016 Outcome Document encourages the development of viable economic alternatives, particularly for communities affected by or at risk of illicit cultivation of drug crops. It recommends that States consider development-oriented interventions, 'ensuring that both men and women benefit equally from them, including through job opportunities, improved infrastructure and basic public services and, as appropriate, access and legal titles to land for farmers and local communities.'¹¹ The SDGs also promote access to land tenure as key to meeting targets to eliminate poverty and achieve gender equality.¹² Goal 5 to achieve gender equality and empower all women and girls includes a specific commitment to '[u]ndertake reforms to give women equal rights to economic resources, as well as access to ownership and control over land and other forms of property.'¹³

Women and land tenure in Bolivia

Bolivia continues to make progress in addressing the gender gap in land tenure as part of its efforts to ensure sustainable livelihoods for subsistence farmers in areas that previously had been targeted for crop eradication.

The country's innovative 'coca yes, cocaine no' policy formalized a cooperative cultivation programme initiated in 2004. The programme has been in place since 2006. It permits registered farmers in certain established areas to grow coca over a limited amount of land, a cato equal to 1,600–2,500 square meters, for the legal market as a means to ensure subsistence income. Bolivian law permits 22,000 hectares of coca to be legally cultivated in these 'traditional growing zones' to be sold in legally authorized markets.¹⁴

In 2008, with funding from the European Union, Bolivia designed and implemented a 'community coca control' programme that engages coca-growing communities to monitor and restrict coca planting, and pursue integrated rural development. Coca grown in excess of the authorized amount is subject to eradication. The programme features land titling for coca-growing families and a registry of the cato, the legally authorized coca plot. It also includes biometric registration of authorized growers and a sophisticated database to monitor transport and sales and identify diversion to the illicit market.

8. See N. Affeld, *The Nexus between Drug Crop Cultivation and Access to Land: Insights from Case Studies from Afghanistan, Bolivia, Colombia, Myanmar and Peru* (Berlin: German Agency for International Cooperation, 2014); K. Grimmelmann, J. Espinoza, J. Arnold and N. Arning, 'The Land-Drugs Nexus: How Illicit Drug Crop Cultivation Is Related to Access to Land', *UNODC Bulletin on Narcotics*, vol. 51, no. 17 (2018), pp. 75–104; see also J. C. Muñoz-Mora, S. Tobón and J. W. d'Anjou, 'The Role of Land Property Rights in the War on Illicit Crops: Evidence from Colombia', *World Development*, vol. 103 (2018), pp. 268–283.

9. United Nations Office on Drugs and Crime, *World Drug Report 2015* (2015), p. 116.

10. Affeld, *supra* note 7.

11. UNGASS 2016 Outcome Document, *supra* note 1, para 7(j).

12. Goal 1, indicator 1.4.2; Goal 5, indicator 5.A.

13. Goal 5, Target 5.A.

14. Plurinational State of Bolivia, Ley No. 906 de 2017 (Ley General de la Coca), art. 16(v).

The 'integrated development with coca' policy in Bolivia does not condition development assistance on prior eradication of coca. Instead, by recognizing coca cultivation as a legitimate source of income, the government has helped stabilize household incomes and placed farmers in a better position to assume the risk of substituting illicit crops with alternative crops or livestock.¹⁵

The programme has also played an important role in empowering women coca growers. As of mid-2016, 48 percent of land titles in Trópico de Cochabamba, the department where most coca is legally cultivated, were held by women. This represented the highest percentage of land titled to women in the country.¹⁶ As of 2018, women held title to 35 percent of catos, providing a source of stable income and access to credit.¹⁷ Since 2016, the National Fund for Integrated Development has trained hundreds of women coca farmers to produce a variety of crops, including honey, bananas and pineapple.¹⁸ Evidence shows that women coca growers are successfully diversifying their income. For example, one woman said that her fish pond generated twice the income of a cato and that she was considering abandoning coca cultivation altogether.¹⁹



Coca farmers, Coroico, Nor Yungas Province, Bolivia.

Photo: Emilie Reynaud.

15. T. Grisaffi, L. Farthing and K. Ledebur, 'Integrated Development with Coca in the Plurinational State of Bolivia: Shifting the Focus from Eradication to Poverty Alleviation', *UNODC Bulletin on Narcotics*, vol. 51, no. 17 (2017), pp. 131–157.

16. M. E. Rojas Valverde, *Estudio: Análisis de género; Plan de Acción de Género Gap II 2016–2020* (2017), p. 68.

17. Syscoca Cato Database files, 7 November 2018 (on file with UNDP).

18. Fonadin, *Informe de actividades* (May 2017).

19. T. Grisaffi and K. Ledebur, 'Citizenship or Repression? Coca, Eradication and Development in the Andes', *Stability: International Journal of Security and Development*, vol. 5, no. 1 (2016), pp. 1–19.

Decriminalization

The United Nations international drug control conventions permit the decriminalization of possession and other activities related to possession of controlled drugs for personal, non-medical, non-scientific use.²⁰ The United Nations system common position on drug control policy of November 2018 commits to ‘stepping up our joint efforts and supporting each other... [t]o promote alternatives to conviction and punishment in appropriate cases, including the decriminalization of drug possession for personal use.’²¹ The UN Committee on Economic, Social and Cultural Rights;²² the UN Committee on the Rights of the Child;²³ and UN Special Rapporteurs on health, torture, and extrajudicial, summary or arbitrary executions²⁴ have also called for the decriminalization of possession of controlled drugs for personal, non-medical use to protect individual and public health and to address the harmful consequences of punitive drug policies on people who use drugs.

The UNGASS 2016 Outcome Document encourages the development of ‘alternative or additional measures with regard to conviction or punishment in cases of an appropriate nature’, in accordance with the three drug conventions and other international standards.²⁵ Addressing barriers posed by criminal convictions to employment, social benefits and participation in public life is also important to achieving full and productive employment and decent work (Goal 8.5); reducing inequality within and among countries (Goal 10); and ensuring access to adequate housing (Goal 11.1).

Removing criminal penalties for drug possession for personal use

At least 26 national governments, three states in Australia and 21 jurisdictions in the United States have used the flexibility in the UN drug conventions to remove criminal penalties for possession of drugs for personal, non-medical use, either in law or practice. In some cases this applies to all drugs, and in others only to cannabis. Armenia, Chile, Colombia, Costa Rica, Croatia, the Czech Republic, Ecuador, Estonia, Italy, Latvia, Mexico, Paraguay, Peru, Portugal, Slovenia and Spain have decriminalized possession of small quantities of drugs for personal use.²⁶

20. Single Convention on Narcotic Drugs (as amended by the 1972 Protocol), 520 UNTS 7515 (1961), art. 36; Convention on Psychotropic Substances, 1019 UNTS 14956 (1971), art. 22; Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances, 1582 UNTS 95 (1988), art. 3.

21. United Nations System Chief Executives Board for Coordination, *supra* note 6, annex I.

See also:

- World Health Organization, *Consolidated Guidelines on HIV Prevention, Diagnosis, Treatment and Care for key Populations* (2014);
- *Report of the UN High Commissioner for Human Rights: Study on the Impact of the World Drug Problem on the Enjoyment of Human Rights*, UN Doc. A/HRC/30/65 (2015);
- UNAIDS, *Miles to Go: Closing Gaps, Breaking Barriers, Righting Injustices* (2018);
- World Health Organization, *HIV and Young People Who Use Drugs* (2015), p. 19;
- UN Women, *A Gender Perspective on the Impact of Drug Use, the Drug Trade, and Drug Control Regimes* (2015);
- United Nations Development Programme, *Addressing the Development Dimensions of Drug Policy*, *supra* note 4;
- UNAIDS, United Nations High Commissioner for Refugees, UNICEF, et al., *Joint United Nations Statement on Ending Discrimination in Health Care Settings* (2018);
- Organization of American States, *The Drug Problem in the Americas* (2013).


22. Committee on Economic, Social and Cultural Rights, *Concluding Observations: Philippines*, UN Doc. E/C.12/PHL/CO/5-6 (2016), para. 54.

23. *Joint Open Letter by the UN Working Group on Arbitrary Detention; the Special Rapporteurs on Extrajudicial, Summary or Arbitrary Executions; Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment; the Right of Everyone to the Highest Attainable Standard of Mental and Physical Health; and the Committee on the Rights of the Child, on the Occasion of the United Nations General Assembly Special Session on Drugs* (15 April 2016), www.ohchr.org/Documents/Issues/Health/UNGASS-joint_OL_HR_mechanisms_April2016.pdf.

24. *Ibid.*

25. UNGASS 2016 Outcome Document, *supra* note 1, para. 4(j).

26. N. Eastwood, E. Fox and A. Rosmarin, *A Quiet Revolution: Drug Decriminalisation across the Globe* (London: Release, 2016).



Elena works with the Estonian Association of People Who Use Psychotropic Substances (LUNEST), Estonia's only organization of people who use drugs. LUNEST works to improve harm reduction and opioid substitution programmes, does advocacy to address human rights violations against women who use drugs and, with the government of Estonia, implements a pilot pre-arrest diversion programme.

Photo: Julia Lisnyak.

Possession for personal use is illegal in Germany and the Netherlands; however, guidelines instructing police and prosecutors to avoid arrest or prosecution for small amounts of drugs mean that personal drug possession is *de facto* decriminalized.²⁷ Personal cannabis possession has been decriminalized in Belgium, Georgia, Israel and Switzerland, as well as in three states in Australia.²⁸ In 2018, the Constitutional Court of Georgia ruled that personal cannabis use in private could not be punished.²⁹ The legal framework in Colombia provides for the cultivation of up to 20 plants of coca, cannabis or opium poppy.³⁰

The highest courts in Argentina (2009), Colombia (1994), Mexico (2018) and South Africa (2018) have ruled that criminalization of cannabis possession for personal use or possession and cultivation for personal use violates the right to privacy protected by their respective constitutions.³¹

Bolivia established a regulatory market for non-medical use of coca leaf in 2006.³² Canada,³³ Uruguay³⁴ and ten jurisdictions in the United States³⁵ have created regulated markets for the recreational use of cannabis.



A man gathers marijuana plants for medicinal use in Colombia.

Photo: Jaime Saldarriaga.

27. Ibid.

28. Ibid.; Talking Drugs, *Map: Drug Decriminalisation around the World*, <https://www.talkingdrugs.org/decriminalisation>.

29. Constitutional Court of Georgia, 'Judgment of the Constitutional Court of Georgia on the Constitutional Complaint N1282', 30 July 2018, <https://www.constcourt.ge/en/news/judgement-of-the-constitutional-court-of-georgia-on-the-constitutional-complaint-n1282.page>.

30. Colombia, Ley 599 de 2000 (Código Penal), art. 375; Colombia, Ley 30 de 1986 (Estatuto Nacional de Estupefacientes), art. 2(ñ). The drug law defines a 'plantation' as 'the plurality of plants, in number greater than twenty (20) from which drugs can be extracted that cause dependence'.

31. *Arriola, Sebastián y otros s/ causa n° 9080* (A. 891. XLIV), Corte Suprema de Justicia de la Nación (Argentina), 25 August 2009; *Sentencia C-574/2011*, Corte Constitucional (Colombia), 22 July 2011; *Amparo en Revisión 237/2014*, Suprema Corte de Justicia de la Nación (Mexico), 4 November 2015; *Amparo en Revisión 1115/2017*, Suprema Corte de Justicia de la Nación (Mexico), 11 April 2015; *Amparo en Revisión 623/2017*, Suprema Corte de Justicia de la Nación (Mexico), 13 June 2018; *Amparo en Revisión 547/2018*, Suprema Corte de Justicia de la Nación (Mexico), 31 October 2018; *Amparo en Revisión 548/2018*, Suprema Corte de Justicia de la Nación (Mexico), 31 October 2018; *Minister of Justice and Constitutional Development and Others v. Prince; National Director of Public Prosecutions and Others v. Rubín; National Director of Public Prosecutions and Others v. Acton and Others*, ZACC 30 (South Africa), 18 September 2018.

32. L. Farthing and B. Kohl, 'Supply-Side Harm Reduction Strategies: Bolivia's Experiment with Social Control', *International Journal of Drug Policy*, vol. 23, no. 6 (2012), pp. 488–494.

33. Canada, Cannabis Act (S.C. 2018, c. 16).

34. Uruguay, Ley No. 19.172 de 2013.

35. National Conference of State Legislatures, 'Marijuana Laws', <http://www.ncsl.org/bookstore/state-legislatures-magazine/marijuana-deep-dive.aspx>.



Packed cannabis at a growing facility near the northern city of Safed, Israel. In conjunction with Israel's Health Ministry, cannabis is currently distributed for medicinal purposes to people in Israel.

Photo: Uriel Sinai.

In September 2018, the Constitutional Court of South Africa declared invalid legislation criminalizing the use, possession, purchase and cultivation by adults in private, because it infringed constitutional protections on the right to privacy.³⁶ This judgement thus decriminalized the possession, use and cultivation of cannabis by an adult in private. Public possession or use and possession for use by a child anywhere was not decriminalized. The order of invalidity was suspended for 24 months to give the Parliament of South Africa an opportunity to cure the constitutional defects in current legislation. It also ordered that in the interim, during this period of suspension, it would not be a criminal offence to use, possess or cultivate cannabis in private for personal, private consumption.



A farmer tends to his marijuana plants in Lesotho.
 Photo: Valetudo Cafe.

Box 1: Ending prohibition of cannabis for adult, non-medical use in Mexico

In October 2018, the Supreme Court of Mexico granted its fourth and fifth rulings declaring the prohibition of adult possession and cultivation of cannabis unconstitutional, in violation of fundamental rights to free development of personality and health protected by the Constitution. Under Mexican law, five consecutive Supreme Court rulings on the same issue and in the same direction are required to make the decision binding on all judges nationally. These rulings provide constitutional protection from prosecution for the parties before the court. The rulings also establish that courts should rule in favour of adult possession and cultivation for non-medical use in the future.

The next step towards legalization is for Congress to reform the laws the court found unconstitutional. If Congress does not act, the Supreme Court could strike the law criminalizing possession and cultivation for personal use.

On 8 November 2018, Senator Olga Sánchez Cordero, on behalf of the Morena Parliamentary Group, presented a bill in the Mexican Congress that would regulate the use of marijuana for personal, scientific and commercial purposes in accordance with Mexico's Supreme Court rulings.³⁷ At the time of writing, this draft legislation had yet to be taken up by Congress.

36. *Minister of Justice and Constitutional Development and Others v. Prince; National Director of Public Prosecutions and Others v. Rubin; National Director of Public Prosecutions and Others v. Acton and Others*, ZACC 30 (South Africa), 18 September 2018.

37. O. M. C. Sánchez Cordero Dávila and R. Monreal Ávila, 'Iniciativa con proyecto de decreto por el que se expide la ley general para la regulación y control de cannabis', 18 November 2018, http://sil.gobernacion.gob.mx/Archivos/Documentos/2018/11/asun_3772608_20181108_1541679075.pdf.

Pre-booking referral in Seattle, United States

In 2011, the city of Seattle initiated the Law Enforcement Assisted Diversion (LEAD) programme, the first pre-booking diversion programme in the United States. LEAD allows law enforcement officers to redirect people suspected of low-level drug or sex work offences to community-based drug treatment, housing, social and employment services, stipends and legal assistance in a harm reduction framework. Evaluations have shown the programme to be effective in keeping people out of jail and reducing short- and long-term recidivism.³⁸ Participants are also more likely to have housing, employment and legitimate income and benefits.³⁹ More than 25 cities throughout the United States have now adopted pre-booking diversion programmes.⁴⁰

Box 2: Promoting inclusion of communities disproportionately affected by drug control policies in the legal cannabis industry

In many jurisdictions, people from historically marginalized communities have been disproportionately affected by high rates of arrest and incarceration for cannabis and other drug-related crimes. Evidence shows that criminalization has long-term effects on those arrested and incarcerated, as well as their families and communities.

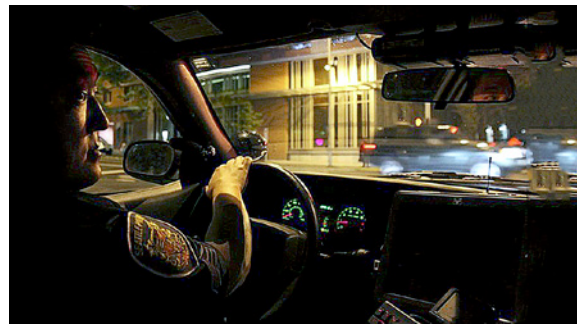
In the United States, the state of Massachusetts legalized adult use and commercial production and sale to adults of marijuana for non-medical purposes in 2017. Massachusetts law requires its State Cannabis Commission to adopt policies and procedures to promote inclusion in the marijuana industry of people from communities that have been disproportionately harmed by marijuana prohibition and enforcement and to positively affect these communities.⁴¹ The commission's Social Equity Program, established in 2018, has two parts.

First, pursuant to law, the commission prioritizes review and licensing for individuals seeking retail, manufacturing or cultivation who can show experience in or business practices that promote economic empowerment in areas of disproportionate impact. Second, the commission's programme provides training and technical assistance to qualifying applicants and licensees in several areas, including management, recruitment and employee training; business plan creation; tax and accounting; legal compliance and industry best practices.⁴²

In Colombia, the legal framework for medicinal use of cannabis has provisions to ensure that small cannabis farmers are supported in their efforts to participate in the legal cannabis market. The law requires that all licensed producers purchase 10 percent of their raw material from registered small-scale farmers.

Seattle police drive around Belltown during a 'green-light night', when places in the LEAD programme are offered. The programme offers drug treatment and social help.

Photo: Dean Rutza.



38. S. E. Collins, H. S. Lonczak and S. Clifasefi, 'Seattle's Law Enforcement Assisted Diversion (LEAD): Program Effects on Recidivism Outcomes', *Evaluation and Program Planning*, vol. 64 (2017), pp. 49–56.

39. S. L. Clifasefi, H. S. Lonczak and S. E. Collins, 'Seattle's Law Enforcement Assisted Diversion (LEAD) Program: Within-Subjects Changes on Housing, Employment, and Income/Benefits Outcomes and Associations with Recidivism', *Crime and Delinquency*, vol. 63, no. 4 (2017), pp. 429–445.

40. LEAD National Support Bureau, 'LEAD: Advancing Criminal Justice Reform in 2019', www.leadbureau.org/.

41. See United States, Massachusetts General Laws 94G, Regulation of the Use and Distribution of Marijuana not Medically Prescribed.

42. Massachusetts Cannabis Control Commission, 'Guidance for Equity Provisions' (2018), https://mass-cannabis-control.com/wp-content/uploads/2018/04/FINAL_Social-Provisions-Guidance-Short.pdf.

Women and the criminal justice system

Women and girls are a small percentage of the world prison population, but their numbers have been increasing globally and at a faster rate than for men.⁴³ Worldwide, women incarcerated for non-violent drug-related crimes are the fastest-growing prison population. Many are first-time offenders, incarcerated for minor, non-violent drug-related crimes.⁴⁴ Poor and otherwise marginalized women – such as indigenous women, racial and ethnic minorities and non-nationals – often bear the brunt of harsh anti-drug legislation, incarcerated for minor drug crimes while those responsible for more serious offences, if caught, can use their financial resources to evade or reduce punishment.⁴⁵

Women who use drugs and women who are involved in drug-related crime confront distinct forms of discrimination and barriers to health and other services. This also happens in the criminal justice system. The UNGASS 2016 Outcome Document recognizes this situation and highlights the importance of integrating a ‘gender perspective’ into drug control policies. It urges States to ‘[m]ainstream a gender perspective into and ensure the involvement of women in all stages of the development, implementation, monitoring and evaluation of drug policies and programmes’; develop ‘gender-sensitive’ measures that ‘take into account the specific needs and circumstances faced by women and girls with regard to the world drug problem’; and ‘implement the Convention on the Elimination of All Forms of Discrimination against Women.’⁴⁶ The UNGASS 2016 Outcome Document highlights the need to address the specific needs of women deprived of liberty, including with respect to health care, in line with the United Nations Rules for the Treatment of Women Prisoners and Non-custodial Measures (the Bangkok Rules).⁴⁷ Such actions support Goal 5 of the SDGs.

Several countries, including Argentina, Colombia, Mexico, Paraguay and Venezuela, have enacted legislative or policy reforms to reduce incarceration and harmful consequences of incarceration on women, taking into account women’s age, economic status, caretaking responsibility and pregnancy.⁴⁸ Sentencing reforms in England and Wales take into account the circumstances of poor, foreign women imprisoned as drug ‘mules’, or couriers.⁴⁹ These reforms provide examples of how countries can translate UNGASS 2016 and SDG commitments into practice.



A female client prays at a community-based drug dependence treatment facility in Indonesia. Photo: Alexandra Radu/PKNI.

43. R. Walmsley, *World Female Imprisonment List*, 4th ed. (London: International Centre for Prison Studies, 2017).

44. Institute for Criminal Policy Research, *Prison: Evidence of Its Use and Over-Use from around the World* (2017).

45. *Report of the Working Group on Arbitrary Detention: Visit to Nicaragua*, UN Doc. A/HRC/4/40/Add.3 (2006), para. 86.

46. UNGASS 2016 Outcome Document, *supra* note 1, para. 4(g).

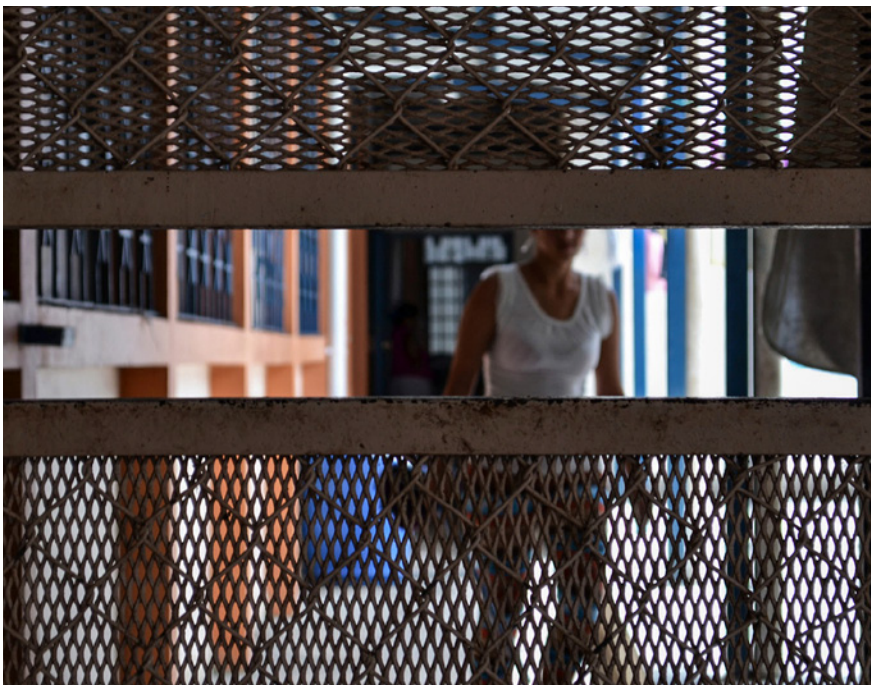
47. *Ibid.*, paras. 4(b), 4(n).

48. See, for example, Mexico, Ley Nacional de Ejecución Penal (decreto) (published in 2016 and entered into force in all states in 2018); Argentina, Código Procesal Penal Federal, art. 330; Paraguay, Código Procesal Penal, art. 238; Paraguay, Código Penal, art. 43; Colombia, Código de Procedimiento Penal, art. 314; Venezuela, Código Orgánico Procesal Penal, art. 245.

49. See UK Sentencing Council, ‘Drug Mules: Twelve Case Studies’, *Analysis and Research Bulletins* (March 2011), www.sentencingcouncil.org.uk/wp-content/uploads/Drug_mules_bulletin.pdf; UK Sentencing Council, *Drug Offences: Responses to Consultation* (2012).

Legal reforms to reduce prison sentences for women in Costa Rica

- Law 9161 (2013) reduces prison sentences for women who smuggle drugs into prison if they live in poverty; are heads of households living in situations of vulnerability; care for minor children, senior citizens or persons with disabilities; or are senior citizens living in conditions of vulnerability. If these conditions are met, the sentence may be served under house arrest, on probation or in an alternative detention centre. Retroactive application of the law resulted in the immediate release of more than 150 women.⁵⁰
- Law 9361 (2017) reduces the time for which criminal records are kept based on the penalty imposed and crime committed. It also permits the elimination of criminal records based on criteria that include the nature of the offence, the length of the sentence and if the person was in a 'situation of vulnerability' when the offence was committed. The initiative was first proposed for women deprived of liberty but was expanded to include men. According to one assessment, 'there is no doubt that this law marks a pivotal moment in the lives of many men and women who have a criminal record and are eager to rebuild their lives.'⁵¹
- Law 9628 (2019) permits sentence reductions for women in situations of vulnerability as a result of poverty, caretaking responsibilities, disability or gender-based violence, where such vulnerability influenced the commission of the punishable act. Importantly, it allows judges to reduce the sentence to below the minimum sentence established for the offence.



J, 28, is a single mother of six. She agreed to carry drugs into a prison to feed her family, but changed her mind at the last second and gave the drugs to prison guards. She was arrested and sentenced to more than five years behind bars. J benefited from a change to Costa Rica's drug law and was released after just four months, but her criminal record makes it nearly impossible to find work. She has no family support, no home, and no job. Her crime will remain on her record for the next ten years.

Photo: Jessamine Bartley-Matthews/WOLA.

50. N. Pieris, *Innovative Approaches to Drug Policy and Incarceration: Reducing Female Incarceration through Drug Law Reform in Costa Rica* (Washington Office on Latin America, International Drug Policy Consortium, Dejusticia and Inter-American Commission of Women, 2017).

51. Washington Office on Latin America, International Drug Policy Consortium, Dejusticia and Inter-American Commission of Women, *Innovative Approaches to Drug Policy and Incarceration: Eliminating Barriers to Re-entry: Criminal Record Reform in Costa Rica* (2017).

Access to opioids for pain relief

People living in low- and middle-income countries, and poor people throughout the world, live and die with little or no access to pain relief or palliative care, according to a 2017 study by global health and palliative care experts.⁵² The World Health Organization considers morphine an essential medicine for the relief of moderate to severe pain and recommends it be available to anyone with medical need.⁵³ Yet most of the world's morphine is consumed by a group of countries that comprise less than 20 percent of the world's population.⁵⁴ In 2015, 61 million people, including 25.5 million people who died, experienced serious health-related suffering that could have been relieved with palliative care or medicines such as oral morphine. More than 80 percent of these people live in low- or middle-income countries where palliative care and oral morphine are limited to non-existent.⁵⁵

Multiple barriers impede access to morphine in low- and middle-income countries. These include overly restrictive drug control laws and regulations, burdensome administrative processes, lack of relevant training for health care workers and fear among health care workers of legal sanctions for prescribing opioids. A focus on preventing diversion of opioids for non-medical use with little consideration for ensuring access to medicines for pain relief is often at the root of this problem.⁵⁶ Meanwhile, in some high-income countries where opioid analgesics are readily available and relied on to treat acute or chronic pain, prescription opioids have contributed to an overdose epidemic



Mercy, a palliative care nurse from Nyeri Hospice, Kenya, provides pain medicines, psychosocial, spiritual and emotional support to Charles, a cancer patient. Nyeri Hospice also provides legal services to Charles and his family members.

Photo: Sven Torfinn.

52. F. M. Knaul et al., 'Alleviating the Access Abyss in Palliative Care and Pain Relief: An Imperative of Universal Health Coverage; The Lancet Commission Report', *Lancet*, vol. 391, no. 10128 (2017), pp. 1–65.

53. World Health Organization, *Ensuring Balance in National Policies on Controlled Substances* (2011).

54. Knaul et al., *supra* note 52.

55. *Ibid.*

56. *Ibid.*; International Narcotics Control Board, *Availability of Internationally Controlled Drugs: Ensuring Adequate Access for Medical and Scientific Purposes* (2016); World Palliative Care Alliance and World Health Organization, *Global Atlas of Palliative Care at the End of Life* (2014).

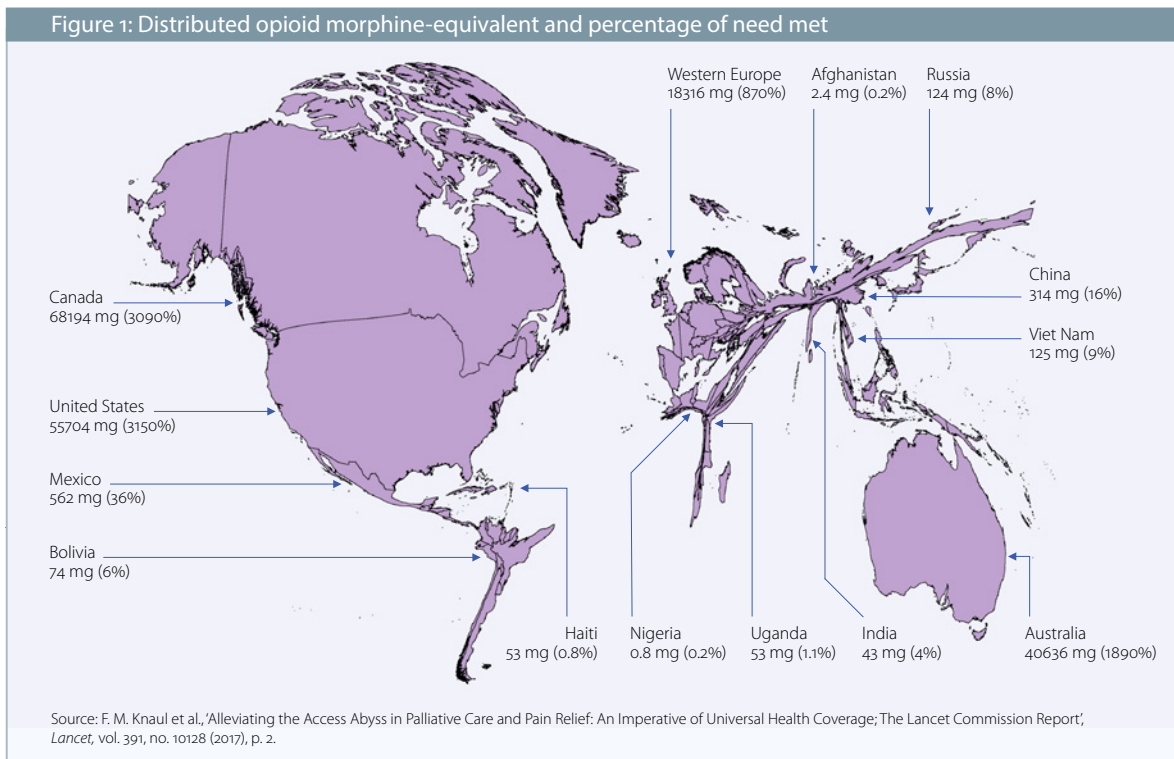


Simon had been gravely ill with Kaposi's sarcoma. Palliative care and antiretroviral care improved his health and his mobility. It also helped restore his relationship with his wife and sons. Here he is at home in Malawi with his sons.

Photo: Nadia Bettega.

of crisis proportions. This is the case in the United States⁵⁷ and, on a much smaller scale, in Canada.⁵⁸ This situation provides important lessons for governments seeking to balance their obligation to ensure access to opioid analgesics for pain relief with their obligation to minimize non-medical use.

The UNGASS 2016 Outcome Document articulates a strong commitment to ‘improving access to controlled medicines for medical and scientific purposes’. It also calls for specific steps to address barriers to access, including ‘those related to legislation, regulatory systems, health-care systems, affordability, the training of health care professionals, education, awareness-raising, estimates, assessment and reporting, benchmarks for consumption of substances under control, and international cooperation and coordination.’⁵⁹ Regarding the SDGs, ensuring adequate availability of controlled substances for medical purposes is also critical to achieving Goal 3 to ensure healthy lives and promote well-being for all at all ages, in particular the targets on universal health coverage (3.8), access to essential medicines (3.8), ending epidemics and combating communicable diseases (3.3) and strengthening substance abuse prevention and treatment (3.5).



This map shows the distributed opioid morphine-equivalent (morphine in mg/patient in need of palliative care, average 2010–13), and estimated percentage of need that is met for the health conditions most associated with serious health-related suffering. Disparities are striking, with less than 1 percent of need met in Afghanistan, Haiti and Nigeria and an excess of more than 3,000 percent in Canada and the United States.

57. H. Hedegaard, M.D., A. M. Miniño, and M. Warner, 'Drug Overdose Deaths in the United States, 1999–2017', National Center for Health Statistics, Data Brief No. 329 (November 2018).

58. Government of Canada, *National Report: Apparent Opioid-Related Deaths in Canada* (April 2019), <https://infobase.phac-aspc.gc.ca/datalab/national-surveillance-opioid-mortality.html>; Canadian Medical Association, *Harms Associated with Opioids and Other Psychoactive Prescription Drugs* (2015).

59. UNGASS 2016 Outcome Document, *supra* note 1, para. 2.

Palliative care in Mexico

Palliative care for terminally ill individuals, defined by law as having a prognosis of less than six months to live, has been part of Mexico's health law since 2009, when it was amended to provide a right to receive palliative care at health care institutions and at home.⁶⁰ The health law and regulations on palliative care issued in 2013 make clear that essential palliative care medicines must be available and accessible.⁶¹

Despite the health law, pain treatment, a critical component of palliative care, has been difficult to access, especially for people living outside of state capitals or major metropolitan areas. A number of factors have contributed to a shortage of doctors competent or licensed to prescribe strong opioids and of pharmacies to dispense them. These include insufficient training in pain management, challenges in procuring a license to prescribe opioids, complex prescription requirements, limits of prescriptions per provider and complicated guidelines on storage and protection of opioids. In addition, people who suffer severe pain but have more than six months to live are excluded from the health law's protections.⁶²

In recent years, the Mexican government has made important legislative and policy changes to improve safe and adequate access to morphine. These include the development of a national palliative care strategy (2015); the implementation of an electronic system to facilitate prescribing and dispensing opioids (2015);⁶³ the adoption of an inter-agency agreement on palliative care, instructing medical schools to include it in their curricula (2014); and an increase in prescription pads available to providers (2016). Since 2016, Mexico's national health insurance, which covers around 55 million people, has included options for outpatient morphine and other strong opioids as part of the package for palliative care and pain relief services.⁶⁴ These measures have resulted in a significant increase in availability and prescription of morphine and other opioids.⁶⁵

It is important to note that the Mexican government did not act alone. Sustained advocacy by Mexican, regional and global civil society, palliative care organizations, clinicians and academics created and strengthened effective working relationships between these groups and government officials to address specific barriers to pain relief and palliative care.⁶⁶

60. Mexico, Ley General de Salud, 2009, art. 3(XXX).

61. Ibid., art. 166 bis 13.

62. Ibid., art. 166 bis 13; see also J. R. Cossío-Díaz, J. F. Franco González-Salas, D. Kershenobich-Stalnikowitz, et al., 'Regulación de los cuidados paliativos y muerte asistida', *Gaceta Médica de México*, vol. 151 (2015), pp. 119–130; Human Rights Watch, *Care When There Is No Cure: Ensuring the Right to Palliative Care in Mexico* (2014).

63. Comisión Federal para la Protección contra Riesgos Sanitarios, 'Sistema de recetarios electrónicos para medicamentos de Fracción I', <https://www.gob.mx/cofepris/acciones-y-programas/sistema-de-recetarios-electronicos-para-medicamentos-de-fraccion-i>; Comisión Federal para la Protección contra Riesgos Sanitarios, 'Permiso para utilizar recetarios especiales con código de barras de forma subsecuente', <https://www.gob.mx/tramites/ficha/permiso-para-utilizar-recetarios-especiales-con-codigo-de-barras-de-forma-subsecuente/COFEPRIS908>; Consejo de Salubridad General, 'Lanzamiento de recetarios y libros electrónicos', http://www.csg.gob.mx/descargas/pdf/index/noticias_boletines/nota_recetario_libros_electronicos.pdf.

64. M. R. Coronel, 'Ya habrá morfina en Seguro Popular', *El Economista* (20 March 2016), www.eleconomista.com.mx/opinion/Ya-habra-morfina-en-Seguro-Popular-20160320-0007.html.

65. Comisión Federal para la Protección contra Riesgos Sanitarios, *Estrategia nacional para el control del dolor y cuidados paliativos* (on file with UNDP).

66. Human Rights Watch, *supra* note 62; Knaul et al., *supra* note 52.

Medical or therapeutic use of cannabis

At least 48 countries globally and 38 jurisdictions in the United States have established legal and regulatory regimes for the medical or therapeutic use of cannabis or cannabis-based medicines to treat various diseases and symptoms.⁶⁷ A significant number of these programmes have been adopted since the beginning of 2016.⁶⁸ Many jurisdictions vary widely with respect to legal and regulatory frameworks, products allowed and the medical conditions for which cannabis-based medicines are permitted. Such conditions include nausea and vomiting associated with cancer chemotherapy; muscle spasms in patients with multiple sclerosis; some forms of childhood epilepsy; and loss of appetite among patients with AIDS-related wasting.⁶⁹

In June 2017, the International Narcotics Control Board (INCB) published an alert on the therapeutic use of cannabis, noting that a growing number of governments worldwide have authorized the medicinal use of cannabis. It stated that such use was permissible under the Single Convention on Narcotic Drugs of 1961 as amended by the 1972 Protocol, provided certain conditions are met:

- First, governments must submit to the INCB an estimate of anticipated consumption, including details of the number of persons using medical cannabis.
- If cannabis cultivation is planned, the estimate should include information on the area and location of cultivation. A national cannabis agency must be established to supervise cultivation.
- Statistics on cannabis use, stocks and production and information on imports must be provided to the INCB. Import and export authorizations should be required.

The alert also notes that 'the INCB has urged in the past all Governments that have established programmes for the use of cannabis for medical purposes to ensure that the prescription of cannabis for medical use is performed with competent medical knowledge and supervision and that prescription practice is based on available scientific evidence and consideration of potential side effects'.⁷⁰

The World Health Organization's Expert Committee on Drugs has recommended that cannabis be removed from schedule IV of the 1961 Convention. If voted through by the Commission on Narcotic Drugs, this would in effect end the nominal prohibition of the medical use of cannabis under the Convention.

Box 3: Medical use of cannabis in Africa and Asia

In 2017, Lesotho became the first African nation to legalize cannabis cultivation for medicinal and research purposes, followed by Zimbabwe in 2018. South Korea legalized medical marijuana in 2018, the first East Asian country to do so. Finally, in February 2019, Thailand legalized the cultivation, possession and dispensation of medical marijuana.

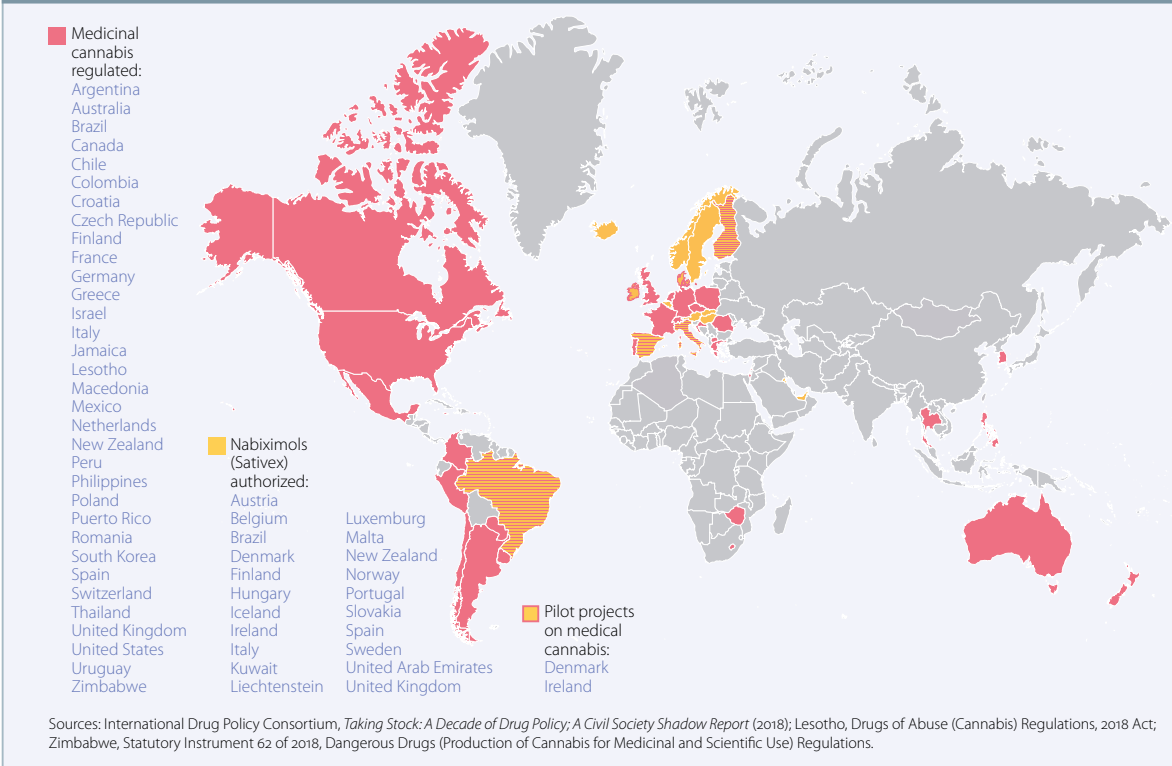
67. International Drug Policy Consortium, *Taking Stock: A Decade of Drug Policy: A Civil Society Shadow Report* (2018). Thirty-four US states, the District of Columbia, Guam, Puerto Rico and the US Virgin Islands permit the medical use of marijuana. National Council of State Legislatures, 'State Medical Marijuana Laws' (11 February 2019), www.ncsl.org/research/health/state-medical-marijuana-laws.aspx.

68. International Drug Policy Consortium, *supra* note 67; National Council of State Legislatures, *supra* note 67.

69. European Monitoring Centre for Drugs and Drug Addiction, *Medical Use of Cannabis and Cannabinoids: Questions and Answers for Policymaking* (2018).

70. International Narcotics Control Board, *The Therapeutic Use of Cannabis* (2017).

Figure 2: Countries that have adopted medical cannabis schemes



Campaigning in Beirut, Lebanon.
 Photo: MENAHARA/IDPC.

Reducing use of the death penalty

The UNGASS 2016 Outcome Document does not mention the applicability of the death penalty for drug offences. However, 74 UN Member States expressed strong opposition to this practice at the event, highlighting this issue as a key concern of the global community.⁷¹ This Outcome Document makes recommendations on proportionate sentencing⁷² and due process and measures to uphold prohibitions of torture and other cruel, inhuman and degrading treatment or punishment.⁷³ These can be read as encouraging States to consider abolition of the death penalty.

Under international law, the death penalty, when used, must be restricted to the ‘most serious crimes’,⁷⁴ which ‘appertain only to crimes of extreme gravity, involving intentional killing.’⁷⁵ Drug offences cannot serve as the basis for the death penalty,⁷⁶ and mandatory death sentences are prohibited.⁷⁷ State parties to the International Covenant on Civil and Political Rights that have abolished the death penalty are barred from reintroducing it.⁷⁸

At least 35 countries and territories maintain the death penalty for drug offences in law.⁷⁹ At least 12 of these do so as a mandatory sanction for certain drug offences,⁸⁰ in violation of international law.⁸¹ At least 1,503 people are known to have been executed for drug-related offences between January 2015 and December 2018. The number of States that retain the death penalty for drug offences in their legislation has not declined in recent years. Still, in some States where sentences or executions are a regular part of the criminal justice system, the number of people executed for drug-related offences has declined since 2015.⁸²

In 2017 and 2018, several States made progressive amendments in their capital punishment laws that could reduce the use of the death penalty. These measures may have a positive impact, but they still fall short of abolishing the death penalty for drug-related crimes and the mandatory death penalty. At the same time, some governments have taken steps in the opposite direction.⁸³

71. UN General Assembly, *Thirtieth Special Session, 1st Plenary Meeting*, UN Doc. A/S-30/PV.1 (2016); UN General Assembly, *Thirtieth Special Session, 2nd Plenary Meeting*, UN Doc. A/S-30/PV.2 (2016); UN General Assembly, *Thirtieth Special Session, 3rd Plenary Meeting*, UN Doc. A/S-30/PV.3 (2016); UN General Assembly, *Thirtieth Special Session, 4th Plenary Meeting*, UN Doc. A/S-30/PV.4 (2016).

72. UNGASS 2016 Outcome Document, *supra* note 1, para. 4(l).

73. *Ibid.*, para. 4(o).

74. International Covenant on Civil and Political Rights, G.A. Res. 2200A (XXI) (1966), art. 6(2).

75. Human Rights Committee, *General Comment No. 36: The Right to Life*, UN Doc. CCPR/C/GC/36 (2018), para. 35.

76. *Ibid.*; Human Rights Committee, *Concluding Observations: Thailand*, UN Doc. CCPR/CO/84/THA (2005), para. 14; Human Rights Committee, *Concluding Observations: Sudan*, UN Doc. CCPR/C/SDN/CO/3 (2007), para. 19; Human Rights Committee, *Concluding Observations: Kuwait*, UN Doc. CCPR/C/KWT/CO/3 (2016), para. 23; Human Rights Committee, *Concluding Observations: Pakistan*, UN Doc. CCPR/C/PAK/CO/1 (2017), paras. 17, 18(a); Human Rights Council, *Question of the Death Penalty: Report of the Secretary-General*, UN Doc. A/HRC/21/29 (2012), para. 24; *Report of the Special Rapporteur on Extrajudicial, Summary or Arbitrary Executions, Christof Heyns*, UN Doc. A/67/275 (2012), para. 122; International Narcotics Control Board, *Annual Report 2017* (2018), para. 257.

77. Human Rights Committee, *General Comment No. 36, supra* note 75, para. 37; Human Rights Committee, *Communication No. 390/1990: Luboto v. Zambia*, UN Doc. CCPR/C/55/D/390/1990/Rev.1 (1995), para. 7.2; Human Rights Committee *Communication No. 1132/2002: Chisanga v. Zambia*, UN Doc. CCPR/C/85/D/1132/2002 (2005), para. 7.4; Human Rights Committee, *Communication No. 1421/2005: Larranaga v. Philippines*, UN Doc. CCPR/C/87/D/1421/2005 (2006), para. 7.2; Human Rights Committee, *Communication No. 1077/2002: Carpo v. Philippines*, UN Doc. CCPR/C/77/D/1077/2002 (2002), para. 8.3.

78. Human Rights Committee, *General Comment No. 36, supra* note 75, para. 35.

79. Harm Reduction International, *The Death Penalty for Drug Offences: Global Overview, 2018* (2019), p. 10.

80. Harm Reduction International, *Interactive Map: Death Penalty for Drug Offences 2018*, <https://www.hri.global/death-penalty-map-2018>.

81. Human Rights Committee, *General Comment No. 36, supra* note 75, para. 37.

82. Harm Reduction International, *The Death Penalty for Drug Offences, supra* note 79, p. 24.

83. The Philippines, for example, has taken steps to reinstate the death penalty for several drug offences.

Box 4: The death penalty and drug-related offences

The National Assembly of Thailand adopted amendments in 2016 to its Narcotics Act that reduced penalties for possession, import/export and production for sale and abolished the mandatory death penalty for the offence of selling prohibited drugs.⁸⁴ These changes came into effect in January 2017.

The Parliament of Iran amended the Law for Combatting Illicit Drugs in 2017 to raise the minimum quantity of drugs required to impose a mandatory death sentence and limit the death penalty to certain crimes.⁸⁵ The law requires that sentences of death or life in prison for those eligible for relief be commuted. If implemented properly, this amendment could allow for the commutation of death sentences for thousands of prisoners.⁸⁶ Executions for drug offences fell 90 percent between 2017 and 2018.⁸⁷

In 2017, the Parliament of Malaysia adopted amendments to the Dangerous Drugs Act of 1952 to introduce some sentencing discretion in the application of the mandatory death penalty for certain drug offences in cases where people convicted of drug trafficking are recognized as couriers and have cooperated with law enforcement.⁸⁸ The revised law applies only to individuals who had not yet been convicted when the amendment came into force, contrary to international standards.⁸⁹

The national drug control policy in Myanmar, adopted in 2018, was developed to align with the UNGASS 2016 Outcome Document and its recommendations and to support achievement of the SDGs. It includes human rights compliance as a key policy area and a cross-cutting issue. To this end, it recommends that consideration be given to repealing the death penalty for drug-related offences.⁹⁰

Figure 3: Global overview 2019: Death penalty for drug offences

At least 35 countries have the death penalty for drug offences

Nearly 40% of all global executions from 2008 to 2018 were for drug offences

12 countries have laws that impose a mandatory death sentence for drug offences

More than 7,000 people globally are on death row for drug offences



Source: Harm Reduction International, *Interactive Map: Death Penalty for Drug Offences 2018*, <https://www.hri.global/death-penalty-map-2018>; Harm Reduction International, *The Death Penalty for Drug Offences: Global Overview*, 2018 (2019).

84. P. Akbar and G. Lai, 'Thailand Amends Drug Law to Reduce Penalties and Ensure More Proportionate Sentencing', International Drug Policy Consortium Blog (15 February 2017), <http://idpc.net/blog/2017/02/thailand-amends-drug-law-to-reduce-penalties-and-ensure-more-proportionate-sentencing>.

85. Iran Human Rights and Ensemble Contre la Peine de Mort, *Annual Report on the Death Penalty in Iran 2017* (2018).

86. Ibid.

87. Harm Reduction International, *The Death Penalty for Drug Offences*, *supra* note 79, p. 8.

88. Kingdom of Malaysia, Dangerous Drugs Act, as amended 2017, art. 39(B)(2)(a); Amnesty International, *Death Sentences and Executions in 2017* (2018), p. 23; Harm Reduction International, *The Death Penalty for Drug Offences*, *supra* note 79, p. 13.

89. Kingdom of Malaysia, Dangerous Drugs Act, as amended 2017, art. 39(B)(2)(b). This is contrary to, among other examples, *UN Safeguards Guaranteeing Protection of the Rights of Those Facing the Death Penalty*, Economic and Social Council resolution 1984/50 (1984), safeguard 2; International Covenant on Civil and Political Rights, G.A. Res 2200A (XXI) (1966), art. 15(1).

90. Republic of the Union of Myanmar, *National Drug Control Policy* (20 February 2018), www.unodc.org/documents/southeastasiaandpacific/2018/02/Myanmar_Drug_Control_Policy.pdf.

Conclusion

Drug policy intersects with many key priorities of the 2030 Agenda and the SDGs. These include health and well-being (Goal 3), gender equality (Goal 5), access to decent work (Goal 8), reducing inequality (Goal 10) and promoting peaceful and inclusive societies (Goal 16). The Outcome Document of the 2016 Special Session of the United Nations General Assembly on the World Drug Problem reflects the growing attention to implications of drug control laws, policies and enforcement practices on people living in poverty and who are otherwise marginalized. It also supports the international consensus that the drug control conventions are sufficiently flexible to allow governments, consistent with international law, to design and implement national drug policies according to their national development priorities and needs. The International Guidelines on Human Rights and Drug Policy are an important tool for assisting governments in the design and implementation of such policies.

This paper describes some of the innovative measures countries have undertaken since the UNGASS in April 2016 to support and implement human rights-based, development-oriented and public health-driven policies. It shows how governments can work towards achieving the commitments made in the 2030 Agenda and the 17 SDGs alongside those made in the UNGASS 2016 Outcome Document, thus illustrating how drug policy and human development objectives can be complementary and mutually reinforcing. It is hoped that the innovative practices documented in this discussion paper will provide UN Member States with practical approaches to address drug-related issues in their respective environmental, economic, political and social circumstances. Innovative measures such as those described above are critical to the efforts of UN Member States to deliver on their pledge to leave no one behind.

Caroline, a clinician at Kimbilio Hospice, Kenya, with her sister Gladys, a hospice guest and patient. Photo: Drew Shafer.





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