

PERSPECTIVE

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People who use drugs and the right to health

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Abstract

Support for a human rights framework for drug policy has been growing for some years. This year, the UNODC published a chapter in the World Drug Report focussed on the right to health. In this paper, we draw attention to the conceptualisation of the right to health for people who use drugs. While one essential element is access to appropriate, high quality, and affordable healthcare, this needs to occur hand-in-hand with two other central components of the right to health – the right to conditions that promote health (the social, economic, legal, commercial, and cultural determinants of health) and the right to meaningful participation in healthcare decisions and in health policy. We consider these three components of a right to health against the current international drug control regime. More specifically we point to how the three drug conventions (1966 as amended 1972, 1971 and 1988) make explicit mention of the right to health. In this way, we argue that duties to respect, protect and provide the right to health for people who use drugs accrue through being a signatory to the drug conventions. Given that there does not appear to be international appetite to abandon the current treaties, and notwithstanding the strong impression that they reinforce a criminalisation approach to people who use drugs, the work herein may afford another avenue for effective advocacy about the right to health.

Keywords Human rights, Right to health, People who use drugs, Treaties, Conventions

Introduction

The “right to health” is a fundamental human right. All people have the right to the enjoyment of the highest attainable standard of physical and mental health that includes complete physical, mental and social well-being and not merely the absence of disease or infirmity [1–4]. People who use drugs have a right to health. In this paper we examine how the conceptualisation of the right to health applies to people who use drugs; how the three international drug conventions represent this right to health; and discuss issues and challenges associated with the right to health for people who use drugs.

Much material has been published about the right to health in the context of drug use and the world drug problem. We were motivated by our involvement in background research for the World Drug Report 2024 chapter on the right to health [5]. In the course of that work, we accessed three bodies of material. The first comes largely from institutions, including multiple bodies within the United Nations, such as the UN Human Rights Council, the UN Office of the High Commissioner for Human Rights, UNAIDS, UNODC, as well as organisations such as the World Health Organization. Much of this material concerns statements about the importance of human rights, analyses from the UN Special Rapporteurs and reports which provide information of interest to governments, institutions and civil society. It includes the ‘International Guidelines on Human Rights and Drug Policy’ [6]. A second body of work comes from advocacy organisations who have published excellent summaries of the importance of human rights particularly for people

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who use drugs. This includes work from Harm Reduction International, Amnesty International, the International Network of People who use Drugs, the International Drug Policy Consortium, and the Global Commission on Drug Policy amongst others [7–13]. Thirdly there is academic literature. This includes research describing human rights abuses experienced by people who use drugs (for some diverse examples, [14–18]), and work analysing issues concerned with upholding rights, for example access harm reduction services by children [19], hepatitis C treatment [20] and safer supply [21]. Finally, some academic work has provided critical reflections on the notion of human rights, given the ways in which its narrow conception can conform to a neoliberal agenda [22–24].

In this paper we steer a path somewhere between these three bodies of work, with specific reference to one of the human rights, the right to health. We identified a gap in the literature concerned with how the drug conventions in particular support the right to health. We find, as detailed below, that there is strong support through the three international drug conventions for the right to health, notwithstanding extensive commentary and argument that the three treaties reinforce a criminalisation approach to people who use drugs [25–31]. We also bring together the official, advocacy, and academic literature to examine three core aspects to a right to health for people who use drugs: access to healthcare, positive social determinants of health, and meaningful participation. Neither of the two authors are legal scholars or have a legal background. As such, we approach our work in relation to the right to health from a social sciences perspective rather than from a legal perspective [32].

People who use drugs and the right to health

There are several aspects to the right to health for people who use drugs. In the World Drug Report 2024 [5] five dimensions are identified: (1) ensuring access to internationally controlled drugs for medical use including for pain management and palliative care; (2) making drug prevention available, accessible, acceptable and quality-, age- and gender-appropriate, including addressing the underlying determinants of health and well-being; (3) making drug treatment available, accessible, acceptable, and quality-, age- and gender-appropriate including measures aimed at minimising the health and social consequences of drug use; (4) ensuring equity and non-discrimination in the realisation of the right to health; and (5) ensuring meaningful participation in all health-related decisions to address the problems related to drug use [5]. We distil these into three aspects for the purposes of this paper: the right to healthcare, the right to positive social determinants of health, and the right to meaningful participation.

The right to healthcare

People who use drugs can experience ill-health, whether as a consequence of their drug use or coincidental to their drug use. As is well-documented through the Global Burden of Disease studies, drug use disorders are associated with significant mortality and morbidity [33]. The right to affordable, accessible, age- and gender-appropriate, acceptable, evidence-informed, high quality healthcare is one component of a right to health for people who use drugs. Self-evidently, this includes drug treatment for those experiencing negative health consequences associated with their drug use.¹

A central concern of the three international United Nations governing conventions for illicit drugs [34–36] to which more than 150 countries are signatories, is the “health and welfare of mankind”. In addition to the overarching goal of the conventions, the conventions also bind signatories to the provision of treatment, rehabilitation and support to people who use drugs. Article 38 of the *Single Convention on Narcotic Drugs* (1961 as amended by 1972 protocol) and Article 20 of the *Convention on Psychotropic Substances*, 1971 requires Parties to “take all practicable measures for the prevention of the abuse of drugs and for the early identification, treatment, education, after-care, rehabilitation and social reintegration of the persons involved” (para 1) and to promote training of personnel in treatment, aftercare and rehabilitation (para 2). Drug treatment that is evidence-based is also reinforced in the Conventions with reference to bodies such as the World Health Organization. For example, Article 14 of the *UN Convention Against Illicit Traffic in Narcotic Drugs and Psychotropic Substances* (1988) requires Parties to adopt appropriate measures aimed at reducing demand for drugs that ‘may be based’ on recommendations of the UN and specialised agencies including the World Health Organization and includes governmental, NGO and private efforts in the fields of prevention, treatment and rehabilitation (para 4). In 2016, Member States committed to “increase the availability, coverage and quality of scientific evidence-based measures, implementing evidence based programmes for treatment of drug use disorders, rehabilitation, recovery and social integration.” [37]. Numerous resolutions of Member States through the Commission on Narcotic Drugs note access to acceptable drug treatment services (for example Resolutions 67/1, 64/3, 64/5, 61/11, and 58/2). Member States have also recognised the importance of voluntary treatment; compulsory treatment is discouraged (Resolution 64/3). The monitoring body for the implementation of the conventions, the International

¹We recognise that drug use does not inevitably lead to health harms. While drug use can compromise a person's health, not all drug use causes health harms, with some drugs and methods of consumption more harmful or more likely to cause harm than others.

Narcotics Control Board (INCB) also promotes the availability of drug treatment [38].

The right to access healthcare for people who use drugs is not just explicitly covered in the drug conventions and its associated governing processes (CND and INCB); it is also an obligation of Member States through other international instruments. The UN *International Covenant on Economic, Social and Cultural Rights* notes that State parties have an obligation to facilitate the treatment of illness and rehabilitation of health (Art. 12 (2c, d)) and prevent, treat and control epidemic and other diseases including drug-related diseases such as HIV. Ensuring treatment for children is covered in the *Convention on the Rights of the Child* (Article 24.1). Drug treatment in prison is supported by the *Basic Principles for the Treatment of Prisoners* (1990) (Art. 9): Prisoners shall have access to the health services available in the country without discrimination on the grounds of their legal situation. This accords with the United Nations *Standard Minimum Rules for the Treatment of Prisoners*, 2015 (Mandela Rules) and UNODC and the World Health Organisation technical guides on treatment for people in custody [39, 40].

The right to healthcare also covers essential medicines. Approximately 75% of the world's population lacks access to pain relief, including for childbirth and palliative care, causing suffering to millions of people [41]. As the latest World Health Organization report shows [42] access to morphine is inadequate in many countries. The United Nations, *Single Convention on Narcotic Drugs, 1961* preamble affirms that the medical use of substances controlled under the treaty “continues to be indispensable for the relief of pain and suffering,” and that “adequate provision must be made” to ensure their availability. The *Convention on Psychotropic Substances 1971* preamble likewise recognises that the medical and scientific use of psychotropic substances is ‘indispensable’ and their availability for such purposes should not be restricted.

Despite the clarity with which the international drug conventions and associated governing processes (for example CND resolutions) oblige member states to provide access to drug treatment and pain relief, there remains significant distance between obligations and implementation. For example, while there is evidence of improvement over the last five years in terms of global coverage of Opioid Agonist Treatment (OAT), there are still almost 100 countries with people who inject drugs where OAT is not available [43]. Globally approximately 82 people out of every 100 people who inject drugs do not receive OAT [43] despite it being on the WHO list of essential medicines. This situation is particularly acute in low- and middle-income countries, reliant on international donor support [44]. There is no independent analysis (that we are aware of) regarding global coverage

for other forms of drug treatment including withdrawal, counselling, or residential rehabilitation. There are analyses of specific regions, for example analysis of the Eastern Mediterranean region highlighted the significant lack of drug treatment services, especially for women [45]. And there are many research studies highlighting the size of the treatment gap for people with substance use disorders [46–51]. Policy is failing with reference to the availability and accessibility of drug treatment; a key component of the right to health.

Aside from the clear lack of availability of drug treatment globally, there are also issues associated with quality [52]. Despite the WHO Standards for the treatment of drug use disorders [53], there is a substantial body of work documenting low quality and non-evidence-informed drug treatment. This includes suboptimal dosing of OAT [54], so-called ‘rehabilitation’ provided in labour camps [55–57], culturally inappropriate care for Indigenous peoples [58] and poor quality and coverage of harm reduction services [59].

The right to healthcare is not limited to treatment for drug-related problems. People who use drugs can also experience health-related concerns and problems independent of their drug use. Research has shown that many people who use drugs experience significant discrimination in accessing routine (non-drug related) healthcare [60–62], as well as when accessing substance use treatment [63–65]. Realising the right to health for people who use drugs requires attention to reducing the stigma and discrimination experienced by people who use drugs when they access healthcare.

Right to the conditions that promote health

Thus far, the focus is on the provision of healthcare services – both drug-related and general healthcare – however the right to health is much more than the provision of healthcare. The right to health refers to the conditions that create health. That is, the underlying determinants of health, including food, clothing, housing, education, social services. The social determinants of health are foundational elements of achieving positive health outcomes for individuals, families and communities [66]. These social determinants are non-medical factors that influence health outcomes and include economic and environmental factors such as unemployment, educational attainment, access to food and water, homelessness and poverty [66–68]. To flourish, people need to be provided with the basic foundations needed to survive and thrive [69–71]. Preventing or delaying the commencement of drug use, given the potential health harms in young people [72] is consistent with attending to the social determinants of health. A focus on housing, education, and reducing poverty and inequality create the conditions to prevent harmful drug use [73–75]. Cultural and

environmental conditions also impact health outcomes [76, 77]. This includes the legal environment; criminalisation of drug use is associated with health harms [78–80]. As such ‘legal determinants’ of health are included within the right to health. Commercial determinants of health are increasingly also recognised as foundational to health outcomes. Commercial determinants relate to private sector activities that impact health and the regulation of commodities that then go on to influence access and use [81]. For example, a for-profit medical system, political influence of pharmaceutical manufacturers and poor regulation concerning opioid access have all been identified as the founding drivers of the fatal opioid overdose epidemic in the US [82, 83]. The high mortality and morbidity associated with alcohol and with tobacco use has been directly linked to the actions of these commercial industries [84, 85] and this now being experienced with reference to previously illicit drugs including cannabis [86, 87] and the psychedelics industry [88].

While the right to conditions that promote health are covered in several international instruments (for example [4, 71, 89]), the right to the social, environmental and economic conditions that support health is also enshrined in the drug conventions. For example, the UN *Single Convention on Narcotic Drugs, 1961* as amended in the 1972 Protocol, Resolution III (“Social conditions and protection against drug addiction”) calls for consideration of the “deplorable social and economic conditions in which certain individuals and certain groups are living predispose them to drug addiction” and recognises the impact of social factors on individual behaviour. The 1971 *Convention on Psychotropic Drugs* requires Parties to “take all practicable measures for the prevention of the abuse of drugs”.

And the UN *Convention Against Illicit Traffic in Narcotic Drugs and Psychotropic Substances, 1988*, in its Preamble, recognises the importance of the social, cultural and welfare dimensions of the world drug problem, and reinforces the desire to eliminate the “root causes of the problem” consistent with attention to the social determinants of health and wellbeing.

The commitment to attending to the social, economic, legal, commercial, and cultural determinants of health for people who use drugs takes government and community responsibility well beyond simply providing healthcare. It entails commitment to poverty-alleviating programs, housing, education, as well as regulation of commercial supply of psychoactive substances. A simple example of one determinant of health – access to clean water – is salutary given the well-documented relationship between the absence of safe water sources and significant injection-related harm, general health including dental health, and self-esteem [90–92]. Another example is limitations placed on people who use drugs to access

poverty-eliminating programs through the application of so-called ‘welfare conditionality’ [93–95]. In terms of the cultural determinants of health, a growing body of scholarship and activism recognises the relationships between drug related harms and dispossession, colonisation with its intergenerational legacies, racism, and the loss of cultural identity [31, 96, 97].

A comprehensive consideration of the social, economic, legal, cultural, and commercial determinants of health, sometimes referred to as ‘structural vulnerabilities’ for people who use drugs [98–100], requires policies far beyond a concern for drugs per se, needing leverage of state welfare, education, housing, and decolonisation policies. A singular focus on access to healthcare has the potential to overlook the structural conditions which impact directly on health.

Meaningful participation

Meaningful participation is a key component of the right to health. As the WHO outline: “Participation requires empowering health service users, communities and civil society to engage in planning, decision-making and implementation processes for health across the programme cycle and at all levels of the system. To be meaningful, participation must include explicit strategies to address power imbalances, value experiential evidence, and manage conflicts of interest so that the needs and expectations of people are met.” [101]. Similar language appears across a number of the official summaries of right to health and participation. For example, in the Sustainable Development Goals, there is emphasis on encouraging and promoting effective “public, public-private and civil society partnerships”. The Joint UN statement on ending discrimination in healthcare settings [102] notes that this can be achieved through “ensuring the participation of affected communities and health workers in the development of health policies”. Yet little consideration is explicitly given to issues of participation for people who use drugs and who are technically engaged in a criminal activity. Madden’s careful work describes the conditions under which people who use drugs experience participation in high-level policy dialogue [103]. As she notes, despite increasing calls for meaningful participation by people who use drugs in policy decision making, “dominant discourses and other drug policy practices are constantly working to enact drug user representatives as illegitimate political subjects, even before they get to the ‘policy table.” (p. vii).

Despite a general healthcare literature showing the impact and positive health outcomes associated with meaningful participation at an individual healthcare level [104, 105] and at the community level [106], little of this work speaks directly to the unique challenges for people who use drugs, such as the pervasive stigma and

discrimination experienced within healthcare settings [62, 107–109]. A growing body of work shows the importance of meaningful engagement of people with lived and living experience of drugs in understanding needs [110] and in designing effective interventions [111, 112]. Beyond individual interventions, the Joint UN Statement on Ending Discrimination [102] highlights the role of the participation of ‘affected communities’ in the development of health policies. Civil society and particularly peer organisations are a potent avenue for meaningful participation in health policies affecting people who use drugs. Civil society has a long history in upholding the right to health [113], and drug user organisations have been fundamental to improving health policies for people who use drugs [114–117]. Being able to carry out these functions, however, requires states to adhere to the right to freedom of assembly and of association [118], as well as facilitate a seat at the table for people whose behaviour is criminalised. This is the irony of the current international drug conventions – despite the core concern with “health and welfare of mankind” the very achievement of this goal with reference to meaningful participation, requires that the criminal penalties noted in the *UN Convention Against Illicit Traffic in Narcotic Drugs and Psychotropic Substances* (1988) must be foregone. Perhaps it is not a surprise then that meaningful participation of the affected community is not explicitly mentioned in the drug conventions, which allows Member States to ignore this aspect of the right to health even though it is noted in the UNGASS 2016 outcomes document (a binding resolution for Member States). It is however codified in several other international instruments – notably Article 25 of the *International Covenant on Civil and Political Rights* and Article 21 of the *Universal Declaration of Human Rights*. As the International Guidelines on Human Rights and Drugs Policy [6] note, a range of actions to facilitate meaningful participation is required, including the removal of legal barriers that prevent participation of people with lived and living experience of drug use, adoption of legislative and institutional measures to facilitate participation of those with living experience, and the removal of laws that deprive people of the right to vote as a consequence of drug convictions.

Discussion

In the 1948 *Universal Declaration of Human Rights* [3] the article concerned with the right to health is embedded within the right to an adequate standard of living to ensure health and wellbeing. (Article 25 [1]: “Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old

age or other lack of livelihood in circumstances beyond his control.”). In this context, it is perhaps not surprising that the ‘right to health’ has required exposition. This exposition has taken place over several decades. The 1966 *International Covenant on Economic, Social and Cultural Rights*, widely considered as the central instrument of protection for the right to health, recognises “the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.” [2, 4].

Despite the argument that the three conventions offer the potential for flexibility [119–121], and that the INCB (as the custodian of the conventions) has noted that decriminalisation and depenalisation are consistent with the provisions of the conventions and do not “automatically require the imposition of conviction and punishment” [38] for drug use or possession for personal use, denial of healthcare and routine conviction of people who use drugs is the norm globally. Member states, responsible for choices around implementation of the conventions and associated resolutions (given the use of words such as “may” and “encourage”) appear to prioritise a criminal response rather than a health response to drug use, even while a central concern of all three conventions is “the health and welfare of mankind”. The drug control system comprises a complex network inclusive of the three conventions plus the resolutions of the Commission on Narcotic Drugs, consensus resolutions that recognise the evolving implementation of the conventions. While the UN might argue that this networked governance between the conventions themselves and the resolutions of the CND represent the implementation work for Member States, the continued denial of the right to health for people who use drugs by many Member States suggests that the resolutions are an insufficient mechanism. We argue that it is the text of the conventions themselves, as symbolic and political governing documents, that Member States defer to. A systemic solution would be to revise the conventions to bring them more into line with the resolutions and international commitments recognising the right to health. There does not appear to be political appetite for this option, and the conventions remain firmly entrenched in policy making as the basis for state drug policy. In this context, we argue that it is helpful and pragmatic to recognise that the text of the conventions themselves oblige signatories to uphold the right to health. Our work demonstrates that the current drug conventions explicitly uphold the right to health. Advocacy, in a context where the conventions retain symbolic political power, can draw on the ways in which the right to health is clearly identified within each of the three drug conventions.

A narrow conceptualisation of the right to health focusses on access to healthcare – drug treatment services, general healthcare services, essential medicines,

and the multiple barriers that impede access to these for people who use drugs (for example [122, 123]). This narrow conceptualisation misses two of the three important co-components of a right to health – the social, economic, legal, commercial, and cultural determinants of health, and meaningful participation. Neither of these other two components is simple or easy to implement, in some cases requiring fundamental challenges to the composition and structure of economies and legal systems and in some cases conflicting with domestic political philosophies. However, without a system that not only allows but supports the meaningful participation of people who use drugs in cultural, civil and economic life, then the right to health for people who use drugs is likely to be limited, or only ever partially realised.

When undertaking the work with the UNODC we were struck by misconceptions about the right to health of people who use drugs. One of these is that the right to health equates to the right to be healthy. This was addressed by the Office of the High Commissioner on Human Rights [1]: “it is more accurate to describe it as the right to the *highest attainable standard* of physical and mental health, rather than an unconditional right to be healthy” (p. 5). A second assumption is that the right to health equates with the right to use drugs. Arguments, both philosophical and practical, about sovereignty over one’s body sit to one side of the right to health as it is articulated in the 1966 International Covenant on Economic, Social and Cultural Rights (where the right to health is most clearly expressed). We would also argue that advocacy about the right to use drugs misses an important opportunity to focus more clearly on the social, cultural and economic determinants of health and meaningful participation. These two often sidelined components of the right to health for people who use drugs deserve substantially more attention. This has been a significant criticism of the human rights agenda more broadly; its failure to attend to human rights concerned with economic, social and cultural rights and the deep structures which perpetuate inequality [32, 124].

In the academic literature there has been critique of the notion of rights, and the attendant individualism, responsabilisation, and neo-liberalism agenda that can be seen to flow through human rights discourses. For example, Whyte’s [124] forensic analysis of the historical roots and present-day representations of human rights facilitates a compelling argument that the neoliberal version of human rights relies on markets and capitalism. The competitive market could be seen to bolster civil and political rights, concerned with ‘rights’ that focus on protecting individual means from political interference, as well as the individual’s right to pursue her own interests in the market. In this sense capitalism, as argued by Whyte, is a system capable of securing rights, justice

and liberty. Yet the very focus on these individual rights enables and allows a dismissal of the social and economic rights which it is so directly in contravention of [124]. This argument aligns with the implicit imperialism [32] associated with some human rights discourses and fits neatly with the analysis of the impacts of colonialism on drug policy [31]. Other drug policy scholars have argued that a neoliberal human rights discourse sees people who use drugs as responsible for their own circumstances. As Moore and Fraser [23] noted, while this has the potential to empower people who use drugs and constitute them as responsible citizens, it also neglects the very socio-economic conditions that perpetuate unequal access to resources [23, 24]. Despite this, advocacy for the human rights of people who use drugs has shown positive results, especially with reference to healthcare and harm reduction to address communicable diseases [125, 126]. The important question seems to be how the right to health might be deployed effectively for advocacy, whilst maintaining a critical stance towards the neoliberal agenda with its baked-in inequality. This requires strong advocacy on the social, economic and cultural determinants of health, recognising community and Indigenous rights that support health and wellbeing.

Conclusions

The right to health encompasses not only the right to access appropriate high-quality and affordable healthcare, but also the right to the structural conditions that promote health and the right to meaningful participation across health and other policies that facilitate the conditions for positive health. For people who use drugs, these three aspects of the right to health are significantly compromised. We have argued that, as signatories to the three international drug conventions, and as Member States have confirmed in various resolutions and international commitments, there is a duty to attend to the right to health (including a duty to respect, protect, and provide the right to health for people who use drugs). Legal challenges, and human rights impact assessments provide opportunities to advocate for the right to health, noting that the effectiveness of these formal legal mechanisms is yet to be established (see for example [127]). Another mechanism for holding governments to account has been through advocacy for metrics that account for the social determinants of health [128], through community-led monitoring [129, 130], and sustained advocacy to redress the human rights abuses experienced by people who use drugs [131]. We hope this work lends another bow to the advocacy arrow, clearly identifying how the current drug conventions align with the right to health for people who use drugs.

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Author contributions

AR and LB jointly conceptualised the work, conducted the analysis, and prepared the manuscript.

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Data availability

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