**Submission to the Human Rights Council Advisory Committee on patterns, policies, and processes leading to incidents of racial discrimination and on advancing racial justice and equality, pursuant to Human Rights Council Resolutions resolutions 48/18 and 47/21**

**24 October 2022**

**Submitting organisation:**

**Harm Reduction International (HRI)** is a leading NGO dedicated to reducing the negative health, social and legal impacts of drug use and drug policy. HRI promotes the rights of people who use drugs and their communities through research and advocacy to help achieve a world where drug policies and laws contribute to healthier, safer societies.

HRI is an NGO in Special Consultative Status with the Economic and Social Council of the United Nations.
*Contacts:* 61 Mansell Street, E1 8AN, London (UK) Ajeng.larasati@hri.global

HARM REDUCTION
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**Introduction**

Punitive drug policy has been an instrument of repression and oppression inextricably tied to racism and xenophobia, with punitive approaches to drug control being used as a strategy to dehumanise and marginalise people who use or are associated with drugs.[1] Research shows that law enforcement disproportionately targets racialised groups such as black, brown and other minority groups[2], drug-related offences being the main reason used to prosecute and incarcerate people.[3]

In a 2019 statement, the UN Working Group of Experts on People of African Descent stated that:

***'The war on drugs has operated more effectively as a system of racial control than as a mechanism for combating the use and trafficking of narcotics. … [it] has disproportionately targeted people of African descent and disregarded the massive costs to the dignity, humanity and freedom of individuals.'[9]***

The impact of systemic, structural and institutional racism is a prominent issue within drug policy reform. Numerous evidence has been produced and presented by civil society, community-based organisations, academia, as well as UN bodies that shows the disproportionate impact of systemic, structural and institutional racism on people who use or are associated with drugs, particularly those who identify as Black, Brown and Indigenous people.

In that context and considering our experience in international advocacy and research, this submission will focus on providing insights for question number 1, 8, 9 and 22.

**Question 1:**
**Is systemic, structural or institutional racism a prominent issue in your country? Is there any official acknowledgement that systemic/structural/institutional racism exists; and that it is a problem? In what sectors does systemic/structural/institutional racism**

[1] Daniels, C., Aluso, A., Burke-Shyne, N. *et al.* (2021) Decolonizing drug policy. *Harm Reduct J* 18, 120 https://doi.org/10.1186/s12954-021-00564-7

[2] Sentencing Project (2021) The Color of Justice. Racial and Ethnic Disparity in States Prisons. Doi https://www.sentencingproject.org/publications/color-of-justice-racial-and-ethnic-disparity-in-state-priso; Human Rights Council (2021), Promotion and protection of the human rights and fundamental freedoms of Africans and of people of African descent against excessive use of force and other human rights violations by law enforcement officers, A/HRC/47/53 doi https://www.ohchr.org/en/documents/reports/ahrc4753-promotion-and-protection-human-rights-and-fundamental-freedoms-africans; UK Prison Population Statistics. (2021) DOI https://researchbriefings.files.parliament.uk/documents/SN04334/SN04334.pdf

[3] Wang et al., (2022) Beyond the Count: A deep dive into state prison population DOI https://www.prisonpolicy.org/reports/beyondthecount.html#demographics; Statista (2019) Number of sentenced prisoners in the United States under Jurisdiction in 2019, by offence DOI https://www.statista.com/statistics/252852/sentenced-prisoners-in-the-us-under-state-jurisdiction-by-offense/

**occur – for example, access to justice, access to services, enjoyment of socio-economic cultural rights? (Refer to decided cases by national courts where relevant.)**

Harm Reduction International will address this question by focusing on two aspects; on the policing, arrest and over-incarceration as part of drug law enforcement and on access to essential health services, including harm reduction services.

**On policing, arrest and over-incarceration as part of drug law enforcement**[4]

Globally, Black, Brown and Indigenous peoples are disproportionately targeted by drug law enforcement and face unique forms of discrimination across the criminal legal system. In many countries, these communities face higher rates of arrest, prosecution and incarceration for drug offences than the general population, despite similar rates of drug use and selling. According to data from the Global Drug Policy Index 2021, covering 30 countries, several countries studied were singled out as scoring particularly poorly with regards to the disproportionate impacts of the criminal justice response to drugs on ethnic groups, including Brazil, Canada, Mexico, Nepal, South Africa and the UK.[5]

The disproportionate targeting of Black, Brown and Indigenous peoples by drug law enforcement severely impacts their health. A recent literature review focusing on nine countries (Canada, China, India, Malaysia, Mexico, Russia, Thailand, Ukraine and the United States) found that policing is associated with higher risks of HIV infection among people who inject drugs and HIV risk behaviours, including avoidance of harm reduction services.[6] Similarly, fear of detection by law enforcement and the possibility of further increases the likelihood of engaging in high-risk drug-taking behaviours.[7]

Black, Brown, and Indigenous people are overrepresented in the world's prisons. Higher arrest and incarceration rates for these communities do not reflect a higher prevalence of drug use; rather, they are a result of law enforcement's biasedfocus and greater use of violence and force in urban areas, lower-income communities and communities of colour.[8]

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[4] For more details, see HRI and Release's joint submission to OHCHR on "Promotion and protection of the human rights and fundamental freedoms of Africans and of people of African descent against excessive use of force and other human rights violations by law enforcement officers", pursuant to Human Rights Council Resolution 43/1; HRI and Release's joint submission to OHCHR on the "Promotion and protection of the human rights and fundamental freedoms of Africans and of people of African descent against excessive use of force and other human rights violations by law enforcement officers through transformative change for racial justice and equality", pursuant to Human Rights Council resolution 47/21.

[5] Nougier, M. & Cots Fernandez, A., (2021) The Global Drug Policy Index 2021, p. 44, https://globaldrugpolicyindex.net/wp-content/themes/gdpi/uploads/GDPI%202021%20Report%20EN.pdf

[6] Pieter Baker et al., (2020) Policing practices and HIV risk among people who inject drugs – a systematic literature review, *Epidemiologic Reviews*, DOI https://academic.oup.com/epirev/advance-article-abstract/doi/10.1093/epirev/mxaa010/5979505.

[7] UNODC (2016) World Drug Report 2016 DOI https://www.unodc.org/wdr2016/; Fisher H. & Measham F (2018), Night Lives: Reducing Drug-Related Harm in the Night Time Economy, Durham University, *the APPG on Drug Policy Reform,* The Loop & Volteface.

[8] Drug Policy Alliance, 'Race and the Drug War' DOI https://drugpolicy.org/issues/race-and-drug-war .

In the **UK**, for instance, as of 2017 black people were prosecuted for drug offences at more than eight times the rate of white people and were sentenced to immediate custody nine times the rate of white people.[9] According to another study conducted in London between July and September 2020,[10] in the midst of a global pandemic, of the over 65,000 people stopped and searched, 65% were searched for drugs, with over three-quarters of all searches resulting in no further action. In other words, over 48,000 people were stopped and searched – predominantly for drugs – on the basis of unfounded suspicions. Black men aged 18-24 were 19 times more likely to be stopped and searched than the general population. Black children (aged 10-17) were also stopped and searched at significantly higher rates than white adults and white children.[11]

Similarly, in the **USA**, black people are discriminated against at every stage of the criminal legal process, from policing to pretrial detention, sentencing, parole and post-incarceration. Although black people comprise 13% of the US population and levels of drug use are similar across people of different ethnicity, black people comprise 29% of those arrested for drug offences and represent nearly 40% of those incarcerated in state and federal prisons for drug offences.[12]

**Brazil** is yet another example where the implementation of punitive drug control has clear racial implications. In Brazil, 64% of all people incarcerated are black, while 26% of men in prison and 62% of women in prison are deprived of their liberty for a drug offence.[13]

The consequences of incarceration can transcend individuals and even generations. The incarceration of a parent or breadwinner can impact a family's income and ability to fulfil its basic needs. Their incarceration can impact their health, finances, social stability, and family and personal relationships. Women are particularly affected, as they are usually the primary or sole caregivers in their homes. Negative consequences for children can extend to social exclusion, educational attainment, housing status and health.[14] These effects are compounded

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[9] IDPC (2021), Taking stock of half a decade of drug policy: An evaluation of UNGASS implementation, p. 56, doi http://fileserver.idpc.net/library/UNGASS_5y_Review.pdf

[10] Gatti, U., Tremblay, RE., and Vitaro, F. (2009), Latrogenic effect of Juvenile Justice, *Journal of Child Psychology and Psychiatry*, 50 (8), 991–998; Gilman, AB. (2015), 'Incarceration and the life course: Predictors, correlates, and consequences of juvenile incarceration' [Ph.D Thesis].

[11] Doherty, EE. et al. (2016), 'Examining the consequences of the "prevalent life events" of arrest and incarceration among an urban African-American cohort', Justice Quarterly, 33(6), 970-999.

[12] IDPC, (2021) 'Taking stock of half a decade of drug policy: An evaluation of UNGASS implementation', p. 56, http://fileserver.idpc.net/library/UNGASS_5y_Review.pdf

[13] Ibid.

[14] See, among others: Gatti, U., Tremblay, RE., and Vitaro, F. (2009), 'Iatrogenic effect of juvenile Justice, *Journal of Child Psychology and Psychiatry*, 50 (8), 991–998; Gilman, AB. (2015), 'Incarceration and the life course: Predictors, correlates, and consequences of juvenile incarceration' [Ph.D Thesis]; Gilman, AB., Hill, KG., and Hawkins, JD. (2015), 'When is a youth's debt to society paid? Examining the long-term consequences of juvenile incarceration for adult functioning, *Journal of Developmental and Life-Course Criminology*, 1(1), 33-47; Doherty, EE. et al. (2016), 'Examining the consequences of the "prevalent life events" of arrest and incarceration among an urban African-American cohort', *Justice Quarterly,* 33(6), 970-999.

in the social groups that are more likely to experience incarceration, reinforcing pre-existing inequalities related to race, nationality and class.

**On access to essential health services, including harm reduction services**[15]

Overarching structural racism also negatively affects access to health and harm reduction services. Criminalisation, racism and discrimination against Indigenous, Black and brown people result in low household incomes, unemployment, food insecurity, poor housing and lower levels of education. This, in turn, results not only in worse health outcomes for these communities but also in people from these communities disengaging or actively avoiding health services.

Structural inequalities negatively impact the health of Indigenous people both in Australia and New Zealand. In **New Zealand**, such factors include social deprivation, poverty, the quality of housing and household crowding, which could contribute to inequalities in rates of most infectious diseases.

In the **USA**, there is evidence of racial disparity in access, with Black clients 77% less likely to be prescribed buprenorphine (an opioid agonist medication) than white clients. In **Canada,** a lack of tailored services is reported for Indigenous communities, despite them facing unique challenges and having unique health needs.[16] Hepatitis C incidence is five times higher among Indigenous people,[17] in part due to their overrepresentation in vulnerable populations such as people who inject drugs, people in detention and those with unstable housing.[18] According to the latest available data, cases of active tuberculosis increased by 2.6% from 2016 to 2017. TB incidence was highest among Indigenous people at 21.5 cases per 100,000, and alarmingly high among those identifying as Inuit at 205.8 cases per 100,000.[19] No data is available on the prevalence among people who use or inject drugs.

Indigenous peoples in **Oceania**, specifically Aboriginal and Torres Strait Islander people in Australia and the Māori population in New Zealand, are disproportionately affected by the harms of drug use and consistently experience worse health outcomes than other ethnic groups in the region.[20] This inequality has persisted since the arrival of European settlers and

[15] For more details, see HRI's Submission to the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health on Racism and the Right to health; and HRI, IDPC and Centre for Drug Policy Evaluation's joint submission Submission to the Committee on the Elimination of Racial Discrimination on Issues for consideration during the thematic discussion in preparation for a General Recommendation on Article 5 (e)(iv) of the International Convention on the Elimination of All Forms of Racial Discrimination on Racial discrimination and the right to health.

[16] Global State of Harm Reduction 2020. Harm Reduction International. London, UK, 2020

[17] Ministry of Health (New Zealand). 'High Alert' website launched to help reduce drug harm [Internet]. Ministry of Health NZ2020 [cited 2020 Jul 29]. Available from: https://www.health.govt.nz/news-media/media-releases/high-alert-website-launched-help-reduce-drug-harm.

[18] Global State of Harm Reduction 2020. Harm Reduction International. London, UK, 2020

[19] Global State of Harm Reduction 2020. Harm Reduction International. London, UK, 2020

[20] See, among others: Graham R, Masters-Awatere B. Experiences of Māori of Aotearoa New Zealand's public health system: a systematic review of two decades of published qualitative research. Australian and New Zealand Journal of Public

the beginning of colonialism, with newly imposed healthcare systems focusing primarily on serving those of European descent. Furthermore, Māori people consistently experience barriers when accessing health services, from discriminatory behaviour and inadequate information provision to practical barriers like costs and travel challenges, resulting in Māori people disengaging or actively avoiding health services. Factors contributing to worse health outcomes in Aboriginal and Torres Strait Islander people include a higher prevalence of low household incomes, unemployment, food insecurity, poorer housing and lower level of education compared to the non-Indigenous population. The lack of accessibility to culturally appropriate health services is also apparent. Though there are government-funded Indigenous-specific primary health care services in Australia, the low rate of specialist service use reflects difficulties in accessing these services for many Aboriginal and Torres Strait Islander people.[21]

It has been recognised in **New Zealand** that Māori people have specific health needs, and the Māori Health Strategy was adopted in 2014. However, racism and discrimination across the health system were raised as key issues when the Māori Health Action Plan 2020–2025 was developed. Inequalities are reflected in the higher burden of drug-related infectious diseases. For example, hepatitis C prevalence is higher among Aboriginal and Torres Strait Islander people who inject drugs compared to non-Indigenous people who inject drugs. However, research in Australia found that factors associated with hepatitis C infection were the same for Indigenous and non-Indigenous people who inject drugs - imprisonment, sharing injecting equipment in prison - but the extent of exposure to these factors differed. In particular, incarceration rates are higher for Indigenous people in both countries. In **Australia**, Aboriginal and Torres Strait Islander people represented 28% of the prisoner population in 2019 while accounting for 3.3% of the general population. In New Zealand in 2019, 52% of the prison population was Māori people, while they represented 16.5% of the general population.[22]

**Question 8:**
**How has the ongoing COVID-19 pandemic brought to the surface and exacerbated systemic, structural or institutional racism?**

The COVID-19 pandemic has revealed systemic bias and barriers to access to health services for racialised people. Data shows that the pandemic has disproportionately affected ethnic

Health 2020;44(3):193–200; Markwick A, Ansari Z, Sullivan M, Parsons L, McNeil J. Inequalities in the social determinants of health of Aboriginal and Torres Strait Islander People: a cross-sectional population-based study in the Australian state of Victoria. International Journal for Equity in Health 2014;13(1):91; Pearson O, Schwartzkopff K, Dawson A, Hagger C, Karagi A, Davy C, et al. Aboriginal Community Controlled Health Organisations address health equity through action on the social determinants of health of Aboriginal and Torres Strait Islander peoples in Australia. [Internet]. BMC Public Health - In Review; 2020 [cited 2020 Aug 18]. Available from: https://www. researchsquare.com/article/rs-25090/v1; Zambas SI, Wright J. Impact of colonialism on Māori and Aboriginal healthcare access: a discussion paper. Contemp Nurse 2016;52(4):398–409.

[21] Global State of Harm Reduction 2020. Harm Reduction International. London, UK, 2020 DOI https://www.hri.global/global-state-of-harm-reduction-reports

[22] Ibid

minority groups and racialised people, who have experienced higher rates of infections, hospital stays and deaths caused by COVID-19 than the white population. For example, in the **UK,** Bangladeshi ethnic group had the highest rate of COVID-related deaths, which is 2.7 times higher than males in the White British ethnic group, followed by Pakistani males (2.2 times) and Black Caribbean males (1.6 times). Pakistani women had the highest rate of death involving COVID-19, 2.5 times higher than females in the White British ethnic group, followed by Bangladeshi females (1.9 times) and females in the Mixed ethnic group (1.4 times)[23]. According to the Centres for Disease Control and Prevention, American Indians or Alaska Natives are at higher risk of infection (1.6 times), hospitalisation (2.7 times) and death (2.1 times) compared to the white non-Hispanic population. In turn, Black African American and Hispanic populations are over twice as likely to stay in the hospital in case of contracting covid and around 1.7 times at higher risk of dying than the white non-Hispanic population[24].

To the disproportionate impact of the COVID-19 pandemic on ethnic minority groups and racialised populations, we must add the risks that drug use can pose to these groups, as they are often the targets of drug law enforcement, as already illustrated in the answer to question number one above. Evidence indicates that people who use drugs, particularly people who inject or smoke, face more significant risks of infection and elevated risk of adverse outcomes if contracting the virus compared to the general population associated - among others - with pulmonary and respiratory complications, compromised immune system as a consequence of the prolonged drug consumption.[25] Additionally, people who inject drugs can have existing underlying medical conditions that increase the risk of COVID-19, such as HIV, viral hepatitis, and tuberculosis. Indeed, research shows that since 2020, deaths from overdose have increased by 30.9% in the US, while poor health outcomes associated with substance use have been particularly amplified during the pandemic.[26] Additionally, structural factors such as stigma and discrimination can limit the healthcare engagement of people who use drugs, leading them to disengage or actively avoid institutional healthcare settings.[27] Similarly, barriers to accessing health services can also undermine people's uptake of COVID-19 vaccines. However, people who use drugs in general - and people who use drugs

[23] Office for National Statistics (2022) Updating ethnic contrasts in deaths involving the coronavirus (COVID-19), England: 10 January 2022 to 16 February 2022 DOI https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/articles/updatingethniccontrastsindeathsinvolvingthecoronaviruscovid19englandandwales/10january2022to16february2022

[24] Centres for Disease Control and Prevention (2022) Risk for COVID-19 Infection, Hospitalization, and Death By Race/Ethnicity DOI https://www.mayoclinic.org/diseases-conditions/coronavirus/expert-answers/coronavirus-infection-by-race/faq-20488802

[25] Dunlop, A., Lokuge, B., Masters, D. *et al.* (2020) Challenges in maintaining treatment services for people who use drugs during the COVID-19 pandemic. *Harm Reduct Journal* 17-26. Doi https://doi.org/10.1186/s12954-020-00370-7; Vasylyeva, T. I., Smyrnov, P., Strathdee, S., & Friedman, S. R (2020). Challenges posed by COVID-19 to people who inject drugs and lessons from other outbreaks. *Journal of the International AIDS Society*, *23*(7), e25583. https://doi.org/10.1002/jia2.25583; Wang, Q.Q. et al. (2021) COVID-19 risk and outcomes in patients with substance use disorders: analyses from electronic health records in the United States.

[26] Conway, F.N., Samora, J., Brinkley, K. *et al.* Impact of COVID-19 among people who use drugs: A qualitative study with harm reduction workers and people who use drugs. *Harm Reduct J* 19, 72 (2022). https://doi.org/10.1186/s12954-022-00653-1

[27] HRI and UNODC (2022) Tailoring Vaccination Campaigns and COVID-19 Services for People Who Use Drugs Technical Guidance

from racialised communites in particulat -were absent in national and international fora when designing policies and strategies to prevent and control the pandemic. Indeed, WHO does not consider the use of drugs as an underlying health issue when classifying people as at risk of contracting the virus.

**Question 9:**
**To what extent is disaggregated data gathered by state and non-state actors in your country to identify systemic, structural or institutional racism, and to track progress in the measures adopted to address systemic/structural or institutional racism? Is any other data gathering tool used specifically to capture data related to systemic/structural or institutional racism? (Please provide details; refer to quantitative and qualitative data-gathering methodologies, where relevant.)**

Another critical issue is the lack of disaggregated data on drug policy, law enforcement and race – which on itself is a sign of systematic and structural racism, but also has exacerbated the state of racism as it impinges on the ability to adequately assess the interlinkages between drug law enforcement and discrimination against racialised group.[28]

This can be linked to a failure of states to collect data, and/or to an unwillingness to release such information. In **South Africa**, for example, annual crime statistics include figures on drug arrests. However, those figures are aggregated and generalised, "and contain little information relating to the arrest process, conviction rates, and any specific details."[29] Similarly in **Canada**, sources report that no data is collected and released on race and crime, making it difficult to assess the impact of drug law enforcement on specific groups.[30] With regards to health data, criminalisation and disproportionate law enforcement inevitably hinders the collection of realistic, disaggregated data, and work to invisibilise the experiences and needs of certain populations – with a direct impact on availability and acceptability of quality health services.

In the **UK**, Release recommends that all published data which records trends by ethnicity (for example, stop searches, criminal justice outcomes) also disaggregate trends by gender. This data is collected but is often not presented. For example, the annual Police Powers and Procedures reports for England and Wales (which include stop and search, and arrest, data) present a breakdown and comparison by ethnicity, and by sex, but disaggregation by sex and ethnicity is not presented in public facing documents. At the same time, there is also a distinct lack of research on intersectional disproportionality at every stage of the criminal justice system more broadly. The lack of disaggregated data, especially on the targets of drug law

[28] Answer adapted from submissionAdapted from HRI and Release's joint submission to OHCHR on "Promotion and protection of the human rights and fundamental freedoms of Africans and of people of African descent against excessive use of force and other human rights violations by law enforcement officers", pursuant to Human Rights Council Resolution 43/1.
[29] Shaun Shelly, 'Perpetuating Apartheid: South African Drug Policy', in Koram (ed.), The War on Drugs and the Global Colour Line.
[30] Kojo Koram (ed.), The War on Drugs and the Global Colour Line, Pluto Press (2019).

enforcement and the functioning of the criminal legal system, has the effect of making some populations invisible, 'hiding' the experiences of, and potentially disproportionate impact on, specific groups. Importantly, calls for collecting and releasing more accurate data should not translate in increased control and surveillance of already heavily policed groups; but rather focus on the need to adequately evaluate the impact of drug policies, and in turn develop and implement more just and effective ones.

**Question 22:**
**Do you have any recommendations to any stakeholder that you think would advance efforts to address systemic, structural or institutional racism either at the national or international level? Please share those.**

Based on the above, we provide the following recommendations for OHCHR, and other relevant UN agencies:

- Continue to work on advancing the human rights of Black, Brown, and Indigenous group, as well as other racialised communities; including those who use or are associated with drugs. Promote a health-, evidence- and human rights-centred approach to drugs, as also envisaged by the UN System Common Position on Drug Policy;

- Ensure drug control and its impact on racialised groups is explicitly addressed in all discussions at the Human Rights Council, and other relevant fora, where the policies and practices leading to incidents of racial discrimination are addressed; including by meaningfully engaging affected communities in such discussions;

- Urge Member States to:
    - Assess, evaluate, and critically review the unique legal, economic, social and health impacts of domestic drug law enforcement on Black, Brown, and Indigenous group; including by collecting and releasing data which is updated and disaggregated by gender, race, age, and other relevant status;
    - Prioritise public health and human rights centred approaches to drugs, and repeal drug policies that enable violations of international human rights law on the basis of race and ethnicity;
    - Ensure the availability and accessibility of health services, including harm reduction services which adequately address the needs and experiences of Black, Brown, and Indigenous groups. To achieve this, service users should be meaningfully engaged in the design, implementation, and evaluation of harm reduction and drug treatment services;
    - Ensure that drug policy reforms, including those that decriminalise drug use, possession, cultivation and sale, integrate measures that acknowledge and

redress the impact of criminalisation on specific communities, and support those communities in enjoying the economic and social benefits of those reform.

- Identify punitive drug control as a policy that significantly contributes to the disproportionate policing, arrest, and incarceration of people of African descent and other racialised groups, and accordingly endorse the decriminalisation of drug use and possession – as a first steps towards less punitive policies;

- Entrust Special Procedures, such as the Working Group of Experts on People of African Descent, to report on the impact of drug control policies on people of African descent, including /relationship between racism, drug policy and police violence.