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**Submission to the Human Rights Council Advisory Committee in response to the call for input regarding patterns, policies, and processes leading to incidents of racial discrimination and on advancing racial justice and equality**

## Introduction

Open Society Foundations (OSF) make this submission in response to the Advisory Committee's recent request for input on patterns, policies, and processes leading to incidents of racial discrimination and on advancing racial justice and equality. This submission focuses on drug prohibition, an institution that ostensibly aims to improve population health but has deep racist and colonial roots and a long history of causing significant health harm, across communities of color but especially Black and Indigenous communities. In this submission we argue that drug prohibition is *inherently inconsistent* with the right to health and the obligation to eliminate racial discrimination in all its forms. We urge the Advisory Committee to address drug prohibition as a violation of these rights in the study it will present to the 54th session of the Human Rights Council and recommend that the international community move away from this model in favor of an approach to drugs that is based on human rights.

This submission is structured as follows: First, we provide background on OSF's involvement with drug policy. Secondly, we describe key linkages between drug prohibition, the right to health and racial discrimination. Finally, we address some of the Advisory Committee's questions and make specific recommendations for its study report.

## Open Society Foundations' involvement with drug policy

The Open Society Foundations, founded by George Soros, are the world's largest private funder of independent groups working for justice, democratic governance, and human rights. The foundations provide thousands of grants every year through a network of national and regional foundations and offices, funding a vast array of projects. This submission is based on experiences accumulated over thirty years of supporting organizations worldwide that document the harms of drug prohibition, develop and implement activities to mitigate these harms, and advocate for new

approaches to drugs that put human rights, public health, and social support at their center. With more than US$300 million invested, OSF is far and away the largest private donor to fund efforts to understand and address the harms of drug prohibition.

OSF began funding organizations working on drug policy issues in the 1990s because it recognized that drug prohibition was fundamentally at odds with key open society principles such as justice, democratic governance, human rights, sustainable development, transparency, accountability, and participation. An open society approach to tackling a public health and social challenge like drug use, transit, and supply would rely on evidence-based health and social interventions, sustained development assistance, engagement and empowerment of affected communities, de-stigmatization of these communities, and respect for human rights. By contrast, prohibition seeks to solve this challenge through criminalization of affected populations, heavy-handed law enforcement interventions, militarized interdiction, coercive eradication, and stigmatization.

Through decades of work in this field, we have seen over and over again how drug prohibition tends to go hand-in-hand with authoritarian tendencies, to disproportionately affect or target marginalized populations, and to involve the unaccountable expenditure of huge amounts of public funds on mostly ineffective and punitive drug control measures. OSF's initial funding in this field roughly coincided with the height of the AIDS epidemic which starkly highlighted prohibition's harms as the HIV virus spread like wildfire among people who injected drugs and who had had little or no access to health and social services because they were criminalized and had been driven underground.

Over the last three decades, we have funded hundreds of organizations worldwide that research and document the harms of prohibition, implement program to mitigate these harms, and advocate for drug policy changes. Among others, we have supported documentation of the racist and anti-poor impacts of drug law enforcement globally; the establishment of needle and syringe programs in Eastern Europe, Eurasia, and Eastern Africa; advocacy to legalize medical use of marijuana in the United States; efforts to expand voluntary evidence-based drug treatment programs in countries in Eurasia, Latin America, Eastern Africa and Asia; the pioneering of overdose prevention through naloxone distribution in Asia, Latin America and the United States, and safe consumption sites in Europe and North America; initiatives to reduce the harms associated with stimulant use in Latin America and Asia; efforts to help racialized communities counter police violence and the deadly effects of militarized drug enforcement in the U.S., Latin America and the South East Asia; human rights training and community advocacy for increased national and international funding for harm reduction and drug treatment; and initiatives to decriminalize drug use and possession for personal use in several countries.

While our and others' support for the drug policy field has resulted in a much greater understanding of the harms of prohibition-based drug policies and the development of numerous innovative, community-based, and anti-racist interventions to mitigate these harms, the institution of drug prohibition itself has undergone relatively little

change, despite the legalization of cannabis for medical and/or recreational purposes in some jurisdictions. Millions of people continue to languish in jails and prisons solely for using drugs or because they engaged in petty dealing, cross-border transit or small-scale cultivation as a means of economic survival. Millions more remain at risk of contracting HIV, hepatitis C, or accidental overdose each because of a lack of services. And millions are at risk of violence and human rights abuses that undermine their health that result from the militarization of drug enforcement in producer and transit countries.

**Drug prohibition, the right to health, and racial discrimination**

The official rationale for drug prohibition, as expressed in the preamble of the 1961 Single Convention on Narcotic Drugs, is a concern for the "health and welfare of mankind" due to the "serious evil" that "addiction to narcotic drugs constitutes…for the individual" and the "social and economic danger" that it poses to mankind.[1] In theory, the UN drug conventions are colorblind and should be applied without any distinction as to race, color, economic status, or national or ethnic origin. However, examination of both the origins of prohibition and sixty years of its application in practice shows that drug prohibition is, in fact, inextricably linked at its roots with racial discrimination—and anti-Black racism in particular—and is disproportionately harmful in its impacts on racialized and other marginalized populations.

***The racist origins of drug prohibition***

Drug prohibition is deeply rooted in the colonial past and racist and anti-immigrant sentiments. Western powers, led by the United States, imposed prohibition in the first half of the 20th century, ostensibly out of concern about drug dependence. Mere decades before, however, these same powers had treated psychoactive substances as a commodity that they extracted from their colonies. The British, Dutch and French all engaged in a lucrative global trade in cannabis, coca leaf and opium; Britain even went to war with China to secure continued access to Chinese opium markets.[2]

In the midst of decolonization, however, these countries made an about-face, embracing the US push for drug prohibition, and strongarmed their former colonies into accepting and enforcing this new approach to drugs, in the process depriving these countries of potential revenue streams from which these colonial powers themselves had profited handsomely not long before.[3] Moreover, these countries showed utter disregard for the fact that cannabis, coca, opium and other substances all played important roles in spiritual and healing traditions of many of their former colonies and that prohibition banned and even criminalized these practices.[4] Ironically, European wine producing countries strongly resisted efforts to conclude international agreements on the control of alcohol in that same period.

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[1] United Nations, 1961 Single Convention on Narcotic Drugs. Available at: https://www.incb.org/incb/en/narcotic-drugs/1961_Convention.html (accessed June 9, 2022).
[2] Daniels, C., Aluso, A., Burke-Shyne, N. et al. Decolonizing drug policy. Harm Reduct J 18, 120 (2021). Available at: https://doi.org/10.1186/s12954-021-00564-7 (accessed June 9, 2022).
[3] Ibid.
[4] Ibid.

Racial prejudice played a critical role in the United States' move toward prohibition. Anti-Chinese immigrant sentiments in the late 19th century led to the criminalization of opium smoking which set in motion the progressive criminalization of opium and created a model that was subsequently extended to other psychoactive substances.[5] In the 1930s, US government officials and media actively advanced racist narratives about cannabis, falsely linking it to Mexican immigrants and blaming the substance for severe health consequences such as madness and violence.[6] Another thirty years later, the Nixon administration launched its war on drugs to attack Americans who were seen as a political treat, and especially Black people in the context of the push for civil rights. As Nixon advisor John Ehrlichman later recounted: "[We] had two enemies: the anti-war left and black people… We knew we couldn't make it illegal to be either against the war or black, but by getting the public to associate the hippies with marijuana and blacks with heroin, and then criminalizing both heavily, we could disrupt those communities."[7]

***Racially biased application of prohibition***

The colonial and racist roots of prohibition continue to be an inescapable part of the enforcement and impact of drug prohibition, even at a time when explicit racial bias is no longer socially acceptable. The civil rights lawyer and author Michelle Alexander has famously called mass incarceration in the United States the New Jim Crow as this phenomenon has created a new under-caste of criminalized Black, Brown and Indigenous people whose rights are severely curtailed. "Nothing," she wrote, "has contributed more to the systematic mass incarceration of people of color in the United States than the War on Drugs."[8] Indeed, in 2019, Black people in the US were incarcerated at five times the rate of white people with nearly half sentenced for drug related crimes.[9]

But this is not just a US phenomenon. UK data suggest that police are eight times more likely to stop and search Black people than white people.[10] In Rio de Janeiro, Brazil, 80% of those killed by police are Black or Indigenous and killings often occur during drug enforcement measures.[11] In Indonesia, 9 of 18 people executed for drug offenses in 2015 and 2016 were Africans.[12] In countries like Australia and Canada, Indigenous

[5] Mccaffrey P. 2019. Drug War Origins: How American Opium Politics Led to the Establishment of International Narcotics Prohibition. Master's thesis, Harvard Extension School. Available at: http://nrs.harvard.edu/urn-3:HUL.InstRepos:42004195 (accessed June 9, 2022)
[6] Waxman O. The Surprising Link Between U.S. Marijuana Law and the History of Immigration, Time Magazine, April 19, 2019.
[7] Baum D. Legalize It All. How to win the war on drugs. Harper's Magazine, March 24, 2016.
[8] Alexander M. The New Jim Crow: Mass Incarceration in the Age of Colorblindness, 2010.
[9] NAACP, Criminal Justice Fact Sheet. https://naacp.org/resources/criminal-justice-fact-sheet (accessed June 9, 2022).
[10] Townsend, M, 'Black people'40 times more likely' to be stopped and searched in UK,' The Guardian, May 4, 2019.
[11] Soares, J, 'Racist police violence endures in Jair Bolsonaro's Brazil,' DW.com, 6 October, 2020.
[12] Human Rights Council, Conference room paper: 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, June 28, 2021. Available at: https://www.ohchr.org/sites/default/files/Documents/Issues/Racism/A_HRC_47_CRP_1.pdf (accessed June 29, 2022).

populations are more likely to be arrested and imprisoned for drug offenses.[13] In various European countries, drug charges are much more frequently levied against migrant than native populations. As the Working Group of Experts on People of African Descent noted in 2019, "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."[14]

Even where drug enforcement is not racially biased, prohibition has often devolved into a war on the poor, as people facing poverty are disproportionately targeted by law enforcement, are more likely to be involved in the drug trade as an economic survival strategy, and have fewer legal options to fight arrest or prosecution. In Brazil and the Philippines, where tens of thousands have been killed in the last six years during brutal drug wars launched by these countries' (former) presidents, evidence has repeatedly shown that the vast majority of victims are low wage earners residing in poor, urban neighborhoods.[15]

***Unequal geographic distribution of the harms of drug prohibition***

The worst impacts of drug prohibition have been disproportionately concentrated in the Global South as the following examples demonstrate. Western powers have largely externalized the responsibility to reduce supply of drugs to producer and transit countries in the Global South. Using their economic supremacy, they have pressured countries like Afghanistan, Colombia, Mexico and others to aggressively crack down on growing, production and trafficking of drugs. The ensuing drug wars in these countries have resulted in mass human rights abuses, escalating cycles of violence, rampant corruption, and towering homicide rates.[16] Meanwhile, the predominantly white populations of former colonial powers have by and large avoided these corrosive impacts and their health consequences, despite generating most of the global demand for drugs.

Moreover, the processes the UN drug control treaties created to allow for continued use of allopathic medicines that contain controlled substances were designed for Global North countries with established medical supply processes and strong administrative systems with little concern for their practicability elsewhere. Even today, the availability of medicines like morphine in many low and middle income countries is so inadequate that the majority of people with severe cancer pain cannot access it.[17] This is, in significant part, because the Global North imposed drug control

[13] Australian Human Rights Commission, 'Indigenous Deaths in Custody: Arrest, Imprisonment and Most Serious Offence'; Office of the Correctional Investigator, 'Indigenous People in Federal Custody Surpasses 30%: Correctional Investigator Issues Statement and Challenge,' Government of Canada, January 21, 2020.
[14] OHCHR, 'Fight against world drug problem must address unjust impact on people of African descent, say UN experts,' 14 March, 2019.
[15] See, for example, Rodrigo Duterte's drug war pushed poor families deeper into penury, The Economist, June 2, 2022.
[16] Washington Office on Latin America, Decades of Damage Done: The Drug War Catastrophe in Latin America and the Caribbean, Commentary, June 17, 2021. Available at: https://www.wola.org/analysis/decades-of-damage-done-drug-war-50-years/ (accessed June 9, 2022)
[17] Berterame S, Erthal J, Thomas J, Fellner S, Vosse B, Clare P, Hao W, Johnson DT, Mohar A, Pavadia J, Samak AK, Sipp W, Sumyai V, Suryawati S, Toufiq J, Yans R, Mattick RP. Use of and barriers to access to

requirements that created additional administrative burdens on already weak medicine supply systems in low and middle income countries, which was compounded by the West's subsequent neocolonial demands for structural adjustment measures and for ever more restrictive drug laws in the 1980s. The drug conventions banned the use of controlled substances in traditional medicine, thus barring Indigenous and traditional practitioners from using them legally.

Finally, in many cultures, substances with psychoactive properties played important traditional medicinal and spiritual roles which were abruptly banned with the introduction of the prohibition regime. In Andean countries, for example, Indigenous people revered the coca leaf and used it for traditional medical and spiritual practices. Similarly, some Andean and African indigenous communities have long utilized psychedelic "plant medicines" like ayahuasca, San Pedro, psilocybin containing fungi, ibogaine and others for individual and communal healing and spiritual practice. In Asia and the Middle East, the opium poppy was widely used in traditional medicine and ceremonies. In the Rastafarian, Sufi and Hindu religions, cannabis had a sacred role.[18] Prohibition outlawed all these cultural practices as the UN drug conventions failed to provide for any exemptions from its ban on the production, distribution and use of controlled substances beyond medical (allopathic, rather than traditional) and scientific use.

***Effectiveness of drug prohibition as a global health interventions***

While the UN drug conventions frame drug prohibition as a global health intervention that is supposed to protect the right to health of populations, there is overwhelming evidence that it has not been effective. Despite more than fifty years of efforts to create a "drug-free world," the ultimate goal of drug prohibition, drug use persists at fairly stable levels in every country in the world.[14] According to the UN Office on Drugs and Crime, an estimated 275 million people use drugs worldwide in 2021 and 36 million had a drug use disorder.[19] In a hallmark 2016 report, the Lancet Commission on Public Health and International Drug Policy concluded that that the public health harms of "prohibition far outweigh the benefits."[20]

opioid analgesics: a worldwide, regional, and national study. Lancet. 2016 Apr 16;387(10028):1644-56. doi: 10.1016/S0140-6736(16)00161-6. Epub 2016 Feb 3. PMID: 26852264.

[18] Daniels, C., Aluso, A., Burke-Shyne, N. et al. Decolonizing drug policy. Harm Reduct J 18, 120 (2021). Available at: https://doi.org/10.1186/s12954-021-00564-7 (accessed June 9, 2022).

[19] UNODC, UNODC World Drug Report 2021: pandemic effects ramp up drug risks, as youth underestimate cannabis dangers,
June 24, 2021. Available at: https://www.unodc.org/unodc/press/releases/2021/June/unodc-world-drug-report-2021_-pandemic-effects-ramp-up-drug-risks--as-youth-underestimate-cannabis-dangers.html#:~:text=VIENNA%2C%2024%20June%202021%20%E2%80%93%20Around,Drugs%20and%20Crime%20(UNODC) (accessed June 29, 2022).

[20] Csete J, Kamarulzaman A, Kazatchkine M, et al. Public health and international drug policy. Lancet 2016; 387: 1427–80.

**Alternatives to drug prohibition**

We believe that the cumulative work of the organizations we have supported over the last thirty years leaves no doubt that the prohibition system is *inherently inconsistent* with the right to health and the obligation to eliminate racial discrimination and that the traditional approach of human rights institutions—to focus on the excesses of prohibition—can no longer be justified. It is time for human rights institutions to explicitly call for an end to drug prohibition and the development of a new approach to drugs that is based on human rights, public health and social well-being. Our appeal for this kind of shift in the approach of human rights institutions to drug prohibition is closely aligned with the recent joint statement of UN human rights experts that called for an end to the "war on drugs."[21]

We recognize that drug prohibition is deeply entrenched in countries around the world and that ready-made alternatives that can replace it are often lacking. This gap is in large part due to the fact that prohibition forbade the development of such alternative models. This means that the transition will have to be gradual. We therefore believe that human rights institutions, including this Advisory Committee, should guide States Parties to take steps to reduce further harms from prohibition while at the same time proactively planning and preparing for a transition to a new approach to drugs. In particular, we believe the following steps are essential:

- States Parties should immediately decriminalize drug use and possession for personal use, in line with the 2018 UN System Common Position Supporting the Implementation of the International Drug Control Policy through Effective Inter-agency Collaboration. Laws that criminalize drug use or possession should be amended to remove criminal sanctions.[22]

- States Parties should immediately release persons detained only for drug use or possession for personal use and review their convictions with a view to expunging their records, as recommended by the UN Working Group on Arbitrary Detention.[23]

- States Parties should regularly assess and report on the impacts of drug prohibition on racialized communities through collection and analysis of disaggregated data on drug arrests, prosecutions, sentencing, imprisonment and parole for drug offenses, morbidity and mortality trends in prisons, and the incidence and impact of police interference with drug-related health and

[21] United Nations, End 'war on drugs' and promote policies rooted in human rights: UN experts, 26 June 2022. Available at: https://www.ohchr.org/en/statements/2022/06/end-war-drugs-and-promote-policies-rooted-human-rights-un-experts (accessed June 29, 2022).

[22] Chief Executives Board for Coordination (18 January 2019), Summary of deliberations, Second regular session of 2018, Manhasset, New York, 7 and 8 November 2018, Annex 1, 'UN system common position supporting the implementation of the international drug control policy through effective inter-agency collaboration', CEB/2018/2, pp. 12-14. Available at: https://www.unsystem.org/CEBPublicFiles/CEB-2018-2-SoD.pdf

[23] Working Group on Arbitrary Detention, Arbitrary detention related to drug policies, May 18, 2021. Available at: https://undocs.org/en/A/HRC/47/40

social services.

- State Parties should launch an incremental, evidence-based and participatory process to explore models of regulation for different types of drugs, beginning with the regulation of lower-potency drugs. Countries should maximize development opportunities offered by regulated drug markets and ensure that communities most affected by prohibition are beneficiaries of the process.

**The Advisory Committee's questions**

Below we respond to a selection of the Advisory Committee's questions that we believe are most relevant to the issue of drug prohibition and the elimination of racial discrimination.

**Question 2 (second part): In what sectors does systemic/structural/institutional racism occur – for example, access to justice, access to services, enjoyment of socio-economic cultural rights? (Refer to decided cases by national courts where relevant) & Question 11: In your country, what are the main human rights challenges arising from systemic, structural or institutional racism? List and explain them succinctly**

In many countries, systemic, structural and institutional racism related to drug prohibition cuts across numerous sectors of society. Its prevalence in the law enforcement and justice sectors, where racially biased enforcement has resulted in millions of people being detained, arrested and deprived of their liberty for use, possession, distribution and trafficking of petty amounts of drugs, is particularly well document. But racially biased enforcement of drug prohibition also has profound impacts on access to essential health and social services, resulting in widespread violations of, among others, the rights to health, food, and shelter. Racialized populations disproportionately avoid services for fear of arrest, legal jeopardy, or stigmatizing interactions, are denied access to such services as a result of arrest or imprisonment, or are excluded from certain services due to a past drug convictions or ongoing drug use. Moreover, resources committed to drug enforcement reduce funds available for investment in meeting social, health and other needs of communities affected by drugs. Drug prohibition has major impacts on the safety and security sector, disproportionately affecting low and middle income countries as the vast majority of drug enforcement actions occur in production and transshipment countries in the Global South even though the Global North is the primary consumer of illicit drugs. Similarly, in high income countries drug enforcement occurs disproportionately in racialized and poor communities, resulting in violations of the rights to life and bodily integrity of Black, Brown and Indigenous populations. Finally, prohibition has profound racialized effects on the cultural sector as it resulted in the abrupt and arbitrary ban of long-standing traditional medical and spiritual practices involving psychoactive substances in formerly colonized countries in Africa, Asia, the Middle East, and the Andean region.

**Question 3: What do you consider to be the root causes for systemic patterns of racial inequality?**

We believe that the institution of drug prohibition has been so deeply inculcated in the exercise of discrimination as to represent a major root cause of racial inequality. As noted above, we urge the Advisory Committee to call for an end to this institution and recommend that a new approach to drugs that is based on human rights, public health and social well-being be developed.

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

The impacts of the COVID-19 pandemic and efforts to contain it have exacerbated many of the pre-existing, public health harms associated with drug prohibition. Health services for people who use drugs—often grossly insufficient to start with—were disrupted. Expanded police powers and empty streets due to stay-at-home orders made people who use drugs even more vulnerable than usual to arrest, police harassment, and detention. Illicit supplies of fentanyl-adulterated drugs in the USA increased significantly, leading to a sharp spike in overdose deaths. As services were disrupted and lives upended during the COVID-19 pandemic, fatal drug overdoses were highest among Black and Native American men.[24] Additionally, millions of people detained on non-violent drug charges in countries around the world suddenly faced the prospect of contracting—and potentially dying from—COVID-19 in overcrowded settings of mandatory detention, with little or no ability to comply with physical distancing and other public health recommendations. Each of these COVID-19 pandemic impacts has disproportionately affected racialized and poor communities.

**Question 14: Do you think reparations for the root causes of systemic, structural or institutional racism (such as Transatlantic Slavery, colonialism and apartheid) have a current role to play in redressing systemic, structural or institutional racism, and in eradicating it?**

Drug prohibition is an ongoing colonial and racist legacy; until it is repealed, it will continue to cause harm, predominantly to racialized and poor communities. We believe that reparations are due for these communities and simultaneously the root cause of these harms needs to be remedied. As countries move away from prohibition, it is imperative that they do so in ways that deliberately and explicitly seek to repair harm inflicted on the most affected communities through, among others, expungements of convictions, creation of economic opportunities, and other approaches to compensate harm. A 2021 New York law, the Marijuana Regulation and Tax Act (MRTA), is a good example of how drug policy reform can be anti-racist and begin to repair harms to most affected communities.[25] The MRTA sets aside 50% of all

[24] Han B, Einstein EB, Jones CM, Cotto J, Compton WM, Volkow ND. Racial and Ethnic Disparities in Drug Overdose Deaths in the US During the COVID-19 Pandemic. JAMA Netw Open. 2022;5(9):e2232314. doi:10.1001/jamanetworkopen.2022.32314. Available at: https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2796547#:~:text=During%20March%20to%20August%202021%2C%20overall%20drug%20overdose%20rates%20were,CI%2C%2041.8%2D44.8

[25] New York State Office of Cannabis Management, Marihuana Regulation and Taxation Act (MRTA), undated. Available at: https://cannabis.ny.gov/marihuana-regulation-and-taxation-act-mrta (accessed June 9, 2022).

commercial licenses for "social equity applicants," defined as individuals impacted by cannabis criminalization, Black people and other marginalized communities. In additional to preferential licensing, NY State has developed an "incubator fund" to support social equity applicants to overcome the technical barriers and capital requirements to market participation. Furthermore, forty percent of the MRTA's tax revenue is dedicated to restitution through a Community Reinvestment Fund that will direct resources back into criminalized communities.

**Question 15: How are systemic patterns of racial discrimination addressed within the framework of the Sustainable Development Goals (SDGs) 2030 agenda? In your view, do the SDGs contribute to advance racial justice and equality? (Refer to eg SDGs 1, 3, 4, 5, 6, 7, 8, 10, 11 and16.)**

While the SDGs refer to drugs only once—committing to strengthening the "prevention and treatment of substance abuse, including narcotic drug abuse"—drug prohibition is relevant to many of the SDG targets and goals as prohibition complicates and undermines efforts to achieve many of them. For example, crop eradication pushes many small-scale subsistence farmers for whom opium or coca is their only means of survival further into poverty and food insecurity (SDGs 1 and 2). Criminalization of people who use and sell petty amounts of drugs drives them away from the very health services SDG 3 seeks to promote. Moreover, prohibition is associated with widespread violence, especially in producer and transit countries, increases in illicit financial and arms flows, the proliferation of organized crime groups, and worsening corruption, each of which undermining the achievement of SDG 16. In our view, the SDGs cannot be realized as long as drug prohibition criminalizes racialized and poor communities and makes them targets of militarized drug enforcement. Yet, at present, the SDGs are not used as a vehicle to inform a new approach to drugs that is based on public health, social wellbeing, and human rights.[26]

**Question 16: Is the existing international framework, for example as it relates to the governance of international organisations, sufficient to deal with systemic, structural or institutional racism? If not, what more can be done? & Question 17: Is the existing national legal and human rights framework, if any, sufficient to deal with systemic, structural or institutional racism? If not, what more can be done?**

At present, the international framework, established through the three UN drug control conventions, not only does not offer adequate tools to address systemic, structural and institutional racism related to drug prohibition, it actually perpetuates it. While the UN drug conventions allow for some flexibilities, including the decriminalization of drug use and possession for personal use, the treaties explicitly require drug prohibition and thus compel states to employ a law enforcement approach to this social challenge. In the apt words of one expert, the system

[26] International Expert Group on Drug Policy Metrics, "Aligning Agendas: Drugs, Sustainable Development, and the Drive for Policy Coherence," New York: International Peace Institute, February 2018. Available at: https://www.ipinst.org/wp-content/uploads/2018/02/1802_Aligning-Agendas.pdf

represents "the normalization, through international law, of the use of criminal punishment as a strategy for meeting those [social] goals."[27]

The UN drug control conventions are in clear tension with human rights treaties. For example, when norms, rules or practices result in structural discrimination that disproportionately affects the right to health of already marginalized populations, the right to health imposes both substantive and procedural obligations on State Parties, including an obligation to take special measures aimed at repairing the damage caused to those populations (see General Comment 14 of the Committee on Economic, Social and Cultural Rights). Given the clear evidence that drug prohibition has been a vehicle of structural discrimination and has inflicted disproportionate health harms on racialized and impoverished communities—with the harms often multiplying and compounding[28]—States Parties thus have a clear obligation to act.

In practice, however, the international community's response to drug is guided first and foremost by the UN drug conventions and national legal frameworks overwhelmingly continue to reflect the international prohibition mandate, even though in recent years some countries and jurisdictions have begun rejecting this mandate for cannabis.

We believe that a significant overhaul of the UN drug control conventions, along with analogous changes in national laws and policies, is required to ensure that the international and national frameworks are rooted in human rights and can effectively combat systemic, structural and institutional racism related to drug prohibition.

**Question 18: What are the responsibilities of key stakeholders (UN agencies, states, NHRIs, civil society organisations, technical community and academia, private sector) in addressing systemic, structural or institutional racism and racial discrimination? (Elaborate on what they can do to address systemic patterns of racial inequality.)**

United Nations agencies and programs share considerable responsibility for the harms of drug prohibition. The UN Office on Drugs and Crime (UNODC), the International Narcotics Control Board (INCB) and other agencies have played important roles in establishing the prohibitionist regime in every corner of the globe, despite a growing body of evidence of the profound harms prohibition has caused in many countries and to many communities. The UNODC and INCB continue to wield significant influence with national and international decision makers on drug policy issues; as long as these

[27] https://www.drugfoundation.org.nz/matters-of-substance/archive/february-2016/human-rights-and-the-war-on-drugs/

[28] For example, a person who uses drugs may be driven underground due to criminalization, depriving them access to essential health services such as HIV, hepatitis C and overdose prevention; then incarcerated for drug use and exposed to the health risks associated with imprisonment; and then excluded from key social services such as housing, employment, and education on the basis of their criminal record. Moreover, many users will face additional forms of discrimination based on their gender, race, or other status. Similarly, a person involved in growing of crops may face exposure to toxic chemicals used to eradicate their crop and simultaneously lose their means of existence, affecting their access to clean water, food and health services.

agencies continue to subscribe to the prohibitionist paradigm, disproportionate harm to racialized communities will persist.

It is therefore imperative that UN agencies play a leading role in helping countries to reduce and redress the harms associated with drug prohibition and, going further, assist States Parties in the design, implementation, and monitoring of alternative drug policy models and approaches to ensuring reparations for those who most harmed by prohibition. To start, UN agencies should use the 2018 UN Common Position on Drugs as common agenda toward reducing some key harms associated with prohibition and ending the criminalization of drug use and personal possession. While adopted four years ago, various UN institutions, most notably the UN Commission on Narcotic Drugs, continue to resist a human rights and racial justice approach to drug policy. UN agencies should moreover work with States Parties to develop and implement tools to quantify the racialized impacts of drug prohibition. Finally, UN agencies should be at the forefront of developing alternative models of dealing with the potential health harms associated with drugs, sharing lessons of successful regulatory systems, and assisting States Parties in implementing these new models.

**Question 21: Are there any other 'good practices' by your State or other stakeholders (such as business or civil society organisations) that advance racial justice and equality, and address systemic, structural or institutional racism? If yes, could you please share these practices?**

Over the last thirty years, OSF has invested in many innovative, rights- and community-based, anti-racist approaches to drug policy that we believe constitute best practices, some of which we describe below. However, it is critical to keep in mind that these approaches were developed in the context of—and as a response to—drug prohibition and its harms. They can undo some of the harms of the prohibition system but not the totality of those harms. Therefore, these good practices cannot be seen as a substitute for the more fundamental policy change that is urgently required: the end of drug prohibition itself. These good practices can, however, help inform a new approach to drugs that is based on the right to health, well-being and social support.

***Decriminalization and regulation.*** The disproportionate effects of drug prohibition on marginalized communities cannot be addressed effectively without a move away from a criminal legal approach to drugs. Open Society Foundations has therefore funded various organizations that have advocated for partial or complete decriminalization and regulation of drugs.

- **Ghana.** In 2020, Ghana adopted a new drug law, known as the Narcotics Control Commission Act, which de-penalizes drug possession and use, legalizes harm reduction services, and offers alternatives to incarceration.[29] OSF-grantees POS Foundation and the West Africa Drug Policy Network (WADPN)

[29] Goretti, M, Parliament of Ghana passes historic new drug law, paving the way for a West African approach, IDPC website, April 3, 2020. Available at: https://idpc.net/blog/2020/04/parliament-of-ghana-passes-historic-new-drug-law-paving-the-way-for-a-west-african-approach#:~:text=One%20of%20the%20stated%20purposes,to%20GHC%202%2C400%20%E2%80%93%206%2C000 (accessed June 9, 2022).

had advocated for this law for years given the highly punitive nature of its predecessor. While the new law does not decriminalize drug use, it represents a major step forward as it, among others, replaces mandatory prison terms for drug use and possession with monetary fines, thus significantly reducing the impact of criminalization on people who use drugs.

- **Oregon, USA.** In 2020, voters approved a ballot initiative, supported by OSF-grantees Drug Policy Alliance and Oregon Health Justice Recovery Alliance, to make Oregon the first state in the United States to decriminalize possession and use of all drugs. Under the ballot initiative, possession of controlled substances now carries a maximum fine of US$100 which can be waived if the person calls a hotline for a health assessment. The initiative also directs funds from cannabis taxation proceeds and savings in criminal legal expenses to health and social services, including community-based interventions, for people who use drugs.[30]

***Harm reduction:*** OSF has supported organizations that provide or advocate for services that support the health of people who use drugs without requiring abstinence in dozens of countries worldwide since the 1990s. Collectively known as "harm reduction," these services are not just important best practices for reducing the harms of drug prohibition, they are also a cornerstone for any post-prohibition approach to drugs. At its best, harm reduction is a highly adaptable approach: it should be shaped by the needs of specific communities, and implemented by those communities for those communities. It should not narrowly focus on drugs and drug use but also support community members with challenges related to mental health, housing, access to food, educational needs, the impact of violence, and other factors that influence their welfare. A few specific initiatives that OSF has supported include:

- **Safe consumption rooms in New York City.** OSF is supporting the first ever government-sanctioned safe consumption rooms in the United States located in the neighborhoods of Harlem and the Bronx in New York City.[31] The two sites, operated by a group called OnPoint, serve majority poor, Black and Latino populations in areas with the highest rates of overdose death in the city. Safe consumption rooms, as their name implies, allow people to use drugs in a supervised setting where medical help is available in case of an overdose; they also offer various other health and social services to people who use drugs, including referral to treatment for those who want it. In 2020, one person died from an overdose every hour in New York City for a total 2,000 people, the most on record. While overdose deaths are rising in all population groups, they have grown especially fast in Black, Latinx and Indigenous communities.

[30] Drug Policy Alliance, One Year of Drug Decriminalization in Oregon: Early Results Show 16,000 People Have Accessed Services through Measure 110 Funding & Thousands Have Avoided Arrest, February 1, 2022. https://drugpolicy.org/press-release/2022/02/one-year-drug-decriminalization-oregon-early-results-show-16000-people-have

[31] New York City website, Mayor de Blasio Announces Nation's First Overdose Prevention Center Services to Open in New York City, November 30, 2021. Available at : https://www1.nyc.gov/office-of-the-mayor/news/793-21/mayor-de-blasio-nation-s-first-overdose-prevention-center-services-open-new-york (accessed June 9, 2022).

- **Services for crack users in Brazil.** OSF has supported a pioneering non-abstinence-based housing and employment program for people who are homeless and use crack in São Paolo. This program focuses on supporting Black and Indigenous communities that have been heavily affected by the war on drugs, offering them holistic services to help them improve their health. OSF has also partnered with the Brazilian federal drugs authority to implement a national rollout of this model. In Rio de Janeiro, we supported the establishment of a first-ever community space for people experiencing homelessness who use crack, which benefited entire communities that had been caught between rival drug gangs and regular incursions by both police and army units.

- **Peer-led legal services in Eastern Africa.** In recognition that that access to justice is just as crucial in keeping people healthy as condoms or clean needles OSF has supported peer-led legal services in Eastern Africa and elsewhere. These programs hire and train peer "street lawyers" to work in their communities to track and address the legal needs of people who use drugs and advocate for their rights. This models of street-based legal services has, among others, resulted in many imprisoned people being released to community support instead of prison.[32]

Yours sincerely,

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[32] Open Society Foundations, BRINGING JUSTICE TO HEALTH: The impact of legal empowerment projects on public health, 2013. Available at: https://www.opensocietyfoundations.org/publications/bringing-justice-health (accessed June 9, 2022).