Utrecht University

Netherlands Institute of Human Rights (SIM)
Ethics Institute

Re-visiting the 'principle of balance' from a human rights perspective

Working paper to the 7th Annual Conference of the International Society for the Study of Drug Policy (ISSDP)

Marie Elske C. Gispen, LL.M.

m.e.c.gispen@uu.nl

10-4-2013

Abstract

The international drug control treaties are one of the main barriers that hamper access to controlled medicines, i.e. medicines scheduled as psychoactive substances under the international drug control treaties. The system is based on the principle of balance demanding states to allow medical access whilst maintaining control of non-medical use of psychoactive substances. In practice, however, access to medicines seems dominated by control efforts which results in many human rights violations. Against the background of the poor access to controlled medicines and the many human rights violations caused thereby, this paper presents preliminary findings of analysing the two objectives underlying the principle of balance from a human rights perspective on the basis of a purposefully selected sample of positive legal norms.

Table of Contents

1 Introduction

To understand how the use of psychoactive substances should be regulated in a model of regulation that is fully endorsed by human rights, it is essential to analyse the legal basis of the underlying objectives legitimising drug-control efforts within human rights law. The idea behind this is that designing a human rights-based model of drug-control on the basis of applying human rights norms to the existing international framework of drug-control alone, does not allow analysing the framework's balanced foundation, and would therewith lack a basis in normative human rights law. On that account, singling-out the grassroots objectives underlying the present international drug-control framework and analysing those from a human rights perspective is of significant importance.

Prior to reconsidering the grassroots of drug-control at a normative level, it is first important to identify whether the present understanding of positive human rights norms supports framing the two objectives of drug control as a balanced principle or not. Albeit human rights are in principle non-hierarchical, a certain level of justified prioritization is allowed for the realisation of human rights as their realisation depends to a large extent on available state resources. Positioning the balanced outset of drug-control in a human rights context raises the question whether or not a certain level of prioritization would be appropriate.

In a first attempt to qualify the objectives of drug-control in a human rights context, this paper presents preliminary findings to the research question central to the first phase of the broader research[1]: "How do positive human rights norms qualify the two objectives of drug control?"

The paper sets out with a background section contextualising the focus of this paper. Additionally the research approach taken in this paper and a framework of analysis is elaborated. Consecutively, the main features of human rights law are outlined and a selection of human rights norms is applied to the objectives of drug-control. Finally, preliminary observations are presented.

[1] The findings presented are preliminary in nature and are part of on-going research.

2 Background

The international drug-control framework includes three pillar conventions: the 1961 Single Convention on Narcotic Drugs (Single Convention); the 1971 Convention on Psychotropic Substances (1971 Convention); and the 1988 United Nations Convention Against the Illicit Trafficking in Narcotic and Psychotropic Substances (1988 Convention).[2] The framework is based on a twofold notion that medical access to psychotropic substances should be ensured, whilst their non-medical use and diversion should be diminished.[3] The World Health Organization (WHO) has explained this twofold outset as the 'principle of balance', stating that an effective drug policy "that complies with the spirit of the drug control treaties should […] strike the right balance between the considerations given to these two aims" of drug control.[4] According to the WHO, striking the right balance implies implementing a system of control directed to optimizing access whilst minimizing diversion, in accordance with the international drug-control treaties.[5] It is increasingly accepted, however, that striking the right balance between the two objectives may be problematic within the constraints of the international drug-control treaties themselves. Furthermore, over time drug-control efforts can be interpreted incongruously and have a rather imbalanced effect on society.

For instance, additional provisions are adopted in the international drug-control treaties further strengthening states efforts to control diversion. By omission, the text of the treaties shows that no additional provisions are included, setting a benchmark for states efforts to ensure access to controlled medicines, i.e. medicines scheduled under the international drug-control treaties.[6] Additionally, the international control system is often labelled as setting the pace for prohibitive drug-control policies for it allows states to adopt stricter rules than outlined in the treaties themselves. Access to controlled medicines, however, is seriously hampered under such policies.[7] Moreover, the regulatory control mechanisms of the international drug-control treaties are increasingly referred to as the heart of the problem of poor access to controlled medicines in low-and-middle income countries.[8] For complying with these control mechanisms implies a certain level of government organization, which is, by virtue of their status as a low-and-middle income country, difficult for many of these countries. What is more, the International Narcotics Control Board (INCB), the monitoring body of the international drug-control treaties, has for the longest time

---

2 Single Convention on Narcotic Drugs (adopted 30 March 1961, entered into force 13 December 1964) 520 UNTS 151 (Single Convention); Convention on Psychotropic Substances (adopted 21 February 1971, entered into force 16 August 1976) 1901 UNTS 175 (1971 Convention); United Nations Convention Against the Illicit Traffic in Narcotic Drugs and Psychotropic Substances (adopted 20 December 1988, entered into force 11 November 1990) 1582 UNTS 95 (1988 Convention).

3 Preamble and Art. 4 Single Convention.

4 WHO, *Ensuring Balance in National Policies on Controlled Substances* (Geneva: WHO, 2011), at p. 1.

5 Ibid.

6 See Single Convention; 1971 Convention; K.I. Pettus, 'Rhetoric and the Road to Hell: The International Narcotics Control Regime and Access to Essential Medicines' (2012) 1 Bulletin Health Policy and Law 1, at p. 4.

7 See D. Lohman *et al.*, 'Access to Pain Treatment as a Human Right' (2010) 8 BMC Medicine 1; M. Jelsma, *The Development of International Drug Control: Lessons Learned and Strategic Challenges for the Future* (2011) Working Paper to the First Meeting of the Global Commission on Drug Policy. Available at: http://www.globalcommissionondrugs.org/wp-content/themes/gcdp_v1/pdf/Global_Com_Martin_Jelsma.pdf [last accessed: 9 April 2013].

8 See Yans, R., 2012. *Statement at the Fifth Session of the African Union Conference to Ministers for Drug Control* (2012). Available at: http://www.incb.org/documents/Speeches/Speeches2012/2012_October_CAMDC5_111012_eng.pdf [last accessed: 9 April 2013]; F. Brennan *et al.*, 'Pain Management: A Fundamental Human Right' (2007) 105 Anasthesia & Analgesia 205.

maintained a strong focus on diminishing diversion and strengthening control and has neglected to give similar attention to supporting access to controlled medicines.[9] The result being controlled medicines are widely unavailable today, affecting millions of people, including pain and epilepsy patients, mothers giving childbirth, people in need of acute care or surgery, and injection drug users.[10] The need for controlled medicines is highest in low-and-middle income countries, however, consumption figures demonstrate that controlled medicines are either, not at all, or only on a very limited scale, available in these countries.[11] As a consequence, serious forms of under-treatment and the unavailability of adequate care in general, leads to needless casualties and millions of patients suffering, daily, excruciating and unbearable pain, inhuman and degrading situations, discrimination, and stigma, amongst other things.[12]

The perceived imbalance in drug-control efforts and outcomes has not only affected access to medication. Increasingly, the legitimacy of the international drug-control framework is questioned in international debates, as the number of injection drug users continues to increase annually under present drug-control efforts.[13] Ever-more, drug-control is framed in a human rights context in these debates.

Many human rights violations are reported in the field of drug-control, which are either directly caused by the international drug-control framework, e.g. the poor access to controlled medicines, or are a result of this framework, e.g. discrimination of drug users when denied access to social security schemes.[14] And yet they seem, in many cases, condoned and viewed as the collateral damage of drug-control policies.[15]

Under human rights law, states have different obligations to protect individuals against these violations and to facilitate structures, which enable individuals to enjoy their rights effectively. However, a clash may be perceived between complying with the international drug-control treaties and human rights obligations simultaneously. For instance, as we have seen, it can be argued that the regulatory control procedures of the international drug-control treaties directly hamper states in their ability to ensure access to controlled

---

9 See M.E.C. Gispen, *Poor Access to Pain Treatment: Advancing a Human Right to Pain Relief* (Utrecht: IFHHRO, 2012), at pp. 27-28; A.L. Taylor, 'Addressing the Global Tragedy of Needless Pain: Rethinking the United Nations Single Convention on Narcotic Drugs' (2007) 35 The Journal of Law, Medicine & Ethics 556.

10 See WHO, *Access to Controlled Medications Programme* (2012) World Health Organization Briefing Note. Available at: http://www.who.int/medicines/areas/quality_safety/ACMP_BrNote_PainGLs_EN_Apr2012.pdf [last accessed: 9 April 2013]; WHO, *Epilepsy* (2012) Factsheet No. 999. Available at: http://www.who.int/mediacentre/factsheets/fs999/en/ [last accessed: 9 April 2013].

11 See M.J. Seya, *et al*., 'A First Comparison Between the Consumption of and the Need for Opioid Analgesics at Country, Regional and Global Levels' (2011) 25 Journal of Pain & Palliative Care Pharmacotherapy 6; INCB, *Report of the International Narcotics Control Board on the Availability of Internationally Controlled Drugs: Ensuring Adequate Access for Medical and Scientific Purposes* (2010) E/INCB/2010/1/Supp.1., at para. 5.

12 WHO, Access to Controlled Medications Programme (2012) World Health Organization Briefing Note. Available at: http://www.who.int/medicines/areas/quality_safety/ACMP_BrNote_PainGLs_EN_Apr2012.pdf [last accessed: 9 April 2013];

13 Global Commission on Drug Policy, ~~*War*~~ *on Drugs* (2011). Available at: http://www.globalcommissionondrugs.org/Report [last accessed: 9 April 2013].

14 Count the Costs, *The War on Drugs: Undermining Human Rights*. Available at: http://www.countthecosts.org/sites/default/files/Human_rights_briefing.pdf [last accessed: 9 April 2013].

15 D. Barrett and M. Nowak, 'The United Nations and Drug Policy: Towards a Human Rights-Based Approach' in A. Constantinides and N. Zaikos (eds), *The Diversity of International Law* (Leiden: Martinus Nijhoff Publichers, 2009), pp. 449-477.

medicines including morphine, which is at the same time included in the WHO list of essential medicines and should, as such, be available to anyone at any time under human rights law.[16]

Against this background, broader research is being carried out to design a human rights-based model of drug-control, which includes analysing the drug-control objectives from a human rights perspective.

[16] CESCR, 'General Comment 14' *The Right to the Highest Attainable Standard of Health* (2000) E/C.12/2000/4, at para. 43(d); WHO, *List of Essential Medicines* (2011). Available at: http://whqlibdoc.who.int/hq/2011/a95053_eng.pdf [last accessed: 10 April 2013].

3 Research approach

Analysing how human rights norms qualify the two objectives of drug control is based on a three step process carried out in two phases.

In the first phase of the research, a framework of analysis is established containing step one and step two of the research approach. First, the two objectives of drug control are distinguished from the existing framework of international drug-control. Second, a sample of positive human rights norms is selected purposefully.

The second phase of the research is the application phase, in which, the sample selection of human rights norms is applied to the objectives singled-out. In a table drafted to structure the findings and facilitate the analysis, the sample of state obligations are further broken down into substantive elements and their legal status and basis as well as their specific condition, if any, is qualified. Every single break down of a human rights norm is then linked to the one, or both of the objectives of drug-control singled-out. In addition, the different rights-holders are identified per break down in order to identify which group of people can claim what right under a human rights-based model of drug-control. Ultimately, the table demonstrates how positive human rights norms regard the two objectives of drug control, and a certain level of prioritization, if any, is identified. Such a grassroots legal analysis enables an evaluation of how the two objectives are qualified under human rights law. In order to ground this analysis in the broader field of human rights, the main features of the human rights framework are elaborated first.

The methodology underlying this approach qualifies as legal, including a systemization of different norms on the basis of: plain reading of treaty texts and authoritative soft-law documents; case-law analysis; and literature review. As the paper is part of on-going research, the findings presented are preliminary and the approach taken will be further developed.

4 Framework of analysis

4.1 The objectives of drug control

The use of psychotropic substances has both a positive as well as a negative effect on the protection of public health. On the one hand, their medical use is essential to treat certain diseases and symptoms; on the other hand their non-medical use increases the risk of contracting infectious diseases, leads to dependence disorders, and drug-associated harms.[17] For instance, if used according to medical guidelines, the use of morphine, a derivative of opium, is safe and essential to treat pain[18]; however, the non-medical use of heroin, a derivative of opium as well, leads to an increased risk of contracting HIV/Aids and Hepatitis B and C, and drug-associated harms undermining welfare security at the local and society level.[19] The result being a dual interest of states to both ensure medical access and prevent diversion at the same time. This dual interest translates to the two objectives of drug-control.

4.1.1 The access objective

The first objective distinguished is the "access objective." The main goal of this objective is to ensure adequate treatment is available. According to the preamble of the Single Convention, "the medical use of narcotic drugs continues to be indispensable for the relief of pain and suffering […] and adequate provisions must be made to ensure the availability of narcotic drugs for such purposes."[20] Whereas the Single Convention only refers to pain control and adequate pain medication in particular, the preamble of the 1971 Convention stresses that state parties to the convention recognize that "the use of psychotropic substances for medical and scientific purposes is indispensable and that their availability for such purposes should not be unduly restricted."[21]

Some controlled medicines are considered essential to treat different diseases and symptoms. For instance, morphine is crucial to effective pain control and ergometrine and oxytocin are essential in effectively treating post-partum bleeding of mothers in childbirth.[22] Individuals can only benefit from accessing medicines if medication is actively available, i.e. true access to medicines should be ensured to achieve ensuring adequate treatment is available.[23]

4.1.2 The control objective

The second objective distinguished is the "control objective." The main goal of this objective is to prevent and reduce drug-associated harms both in a public health and a social welfare context. According to the preamble of the Single Convention, the "addiction to narcotic drugs constitutes a serious evil for the individual and is fraught with social and economic danger to

---

17 M.E.C. Gispen, *Poor Access to Pain Treatment: Advancing a Human Right to Pain Relief* (Utrecht: IFHHRO, 2012), at pp. 13-14.

18 WHO, *Cancer Pain Relief* (2nd edition, Geneva: WHO, 1996); WHO, *Ensuring Balance in National Policies on Controlled Substances* (Geneva: WHO, 2011).

19 International Harm Reduction Association (Harm Reduction International), *Global State of Harm Reduction 2008* (London: Harm Reduction International, 2008), at pp. 12-14; See also M.E.C. Gispen, *Poor Access to Pain Treatment: Advancing a Human Right to Pain Relief* (Utrecht: IFHHRO, 2012), at pp. 13-14; Injection drug use section WHO website. Available at: http://www.who.int/hiv/topics/idu/en/index.html [last accessed: 10 April 2013].

20 Preamble Single Convention.

21 Preamble 1971 Convention.

22 WHO, *Medicines: Access to Controlled Medicines (Narcotic and Psychotropic)* (2010) Factsheet No. 336. Available at: http://www.who.int/mediacentre/factsheets/fs336/en/ [last accessed: 10 April 2013].

23 A. Cameron, *Understanding Access to Medicines in Low- and Middle-Income Countries Through the Use of Price and Availability Indicators* (Enschede: Gilderprint Drukkerijen, 2013), at p. 228.

mankind."[24] The 1971 Convention states that state parties to the convention are "determined to prevent and combat abuse of [psychotropic] substances and the illicit traffic to which it gives rise."[25]

In general, drug-control efforts distinguish between three main approaches: a libertarian approach, under which drugs are free available and no formal regulations are put in place; a prohibitive approach, under which laws are designed to achieve complete prohibition; and a regulative approach, under which drugs are permitted under specific legal constraints.[26] Within these different approaches, different models of regulation may be adopted.

4.2 Sampling human rights norms

In principle, the analysis includes only those human rights obligations that directly relate to respecting, protecting, and fulfilling access to medication or the control of drug diversion. The wide range of different human rights violations taking place under the name of drug control, in general are acknowledged, but not taken into account as such. The idea behind this is that in order to understand how human rights norms qualify the two objectives of drug control, the objectives should be understood in a human rights-context rather than in the existing drug-control framework. Hence the principle qualification for a human rights norm to be included in the analysis is its direct correlation with one of the two drug-control objectives.

For instance, fair trial rights are often violated under many drug control policies as drug offenders often face trial in alternative systems of justice.[27] The scope of the right to a fair trial, however, is not principally directed to demanding states to control drug diversion. It is rather directed towards ensuring a system of justice is available in accordance with international fair trial and due process standards.[28]

However, the right to health as adopted in Article 12 of the International Covenant on Economic, Social, and Cultural Rights (ICESCR) protects the right to enjoy a safe and healthy environment, as well as ensuring adequate treatment and essential medicines in particular, including those medicines scheduled under the international drug-control treaties.[29] Additionally, the scope of the freedom from cruel, inhuman, and degrading treatment and punishment (CIDT) is extended to apply to health care settings as well.[30] Increasingly, it is claimed that the denial of access to pain and opioid substitute treatments by means of using opioid medication, is a breach of the freedom from CIDT.[31] Therefore, the

---

24 Preamble Single Convention.

25 Preamble 1971 Convention.

26 T. Boekhout van Solinge, *Dealing with Drugs in Europe: An Investigation of European Drug Control Experiences: France, the Netherlands and Sweden* (Ph.D. Dissertation, Utrecht: Willem Pompe Instituut voor Strafrechtswetenschappen, 2004), at p. 21.

27 Count the Costs, *The War on Drugs: Undermining Human Rights*. Available at: http://www.countthecosts.org/sites/default/files/Human_rights_briefing.pdf [last accessed: 9 April 2013].

28 See Count the Costs, *The War on Drugs: Undermining Human Rights*. Available at: http://www.countthecosts.org/sites/default/files/Human_rights_briefing.pdf [last accessed: 9 April 2013]; HRC, 'General Comment 32' *Article 14: Right to Equality Before Courts and Tribunals and to a Fair Trial* (2007) CCPR/C/GC/32; Art. 14 International Covenant on Civil and Political Rights (adopted 16 December 1966, entered into force 23 March 1976) 999 UNTS 171 (ICCPR).

29 Art. 12 International Covenant on Economic, Social and Cultural Rights (adopted 16 December 1966, entered into force 3 January 1976) 993 UNTS 3 (ICESCR); CESCR, 'General Comment 14' *The Right to the Highest Attainable Standard of Health* (2000) E/C.12/2000/4, at para. 43(d).

30 HRC, 'General comment 20' *Replaces General Comment 7 Concerning Prohibition of Torture and Cruel Treatment or Punishment (Art. 7)* (1992) A/47/40, at para 5.

31 J.E. Méndez, *Report of the Special Rapporteur on Torture and other Cruel, Inhuman or Degrading Treatment or Punishment, Human Rights Council, 22nd session* (2013) A/HRC/22/53. Available at:

analysis is in this phase of research is limited to, but not restricted to in the long run, the relevant substantive elements of the right to health and the freedom from CIDT.

http://www.ohchr.org/Documents/HRBodies/HRCouncil/RegularSession/Session22/A.HRC.22.53_English.pdf [last accessed: 9 April 2013].

5 General characteristics of human rights

5.1 Rights and obligations

Human rights are a set of inalienable rights that all human beings are entitled to for the mere reason of being human.[32]

Traditionally, human rights are classified into civil-and-political rights (CP rights) and economic, social and cultural rights (ESC rights): CP rights being first generation rights, fundamental freedoms, and negative rights; ESC rights being second generation rights, aspirational goals, and positive rights.[33] In this traditional interpretation, it is understood that states should principally refrain from interfering in the life of an individual to respect the enjoyment of CP rights, whereas states should take positive action to effect ESC rights. For instance, in order to enjoy the freedom of expression, states should not interfere with what individuals express. However, in order to enjoy the right to health states, should take active steps to facilitate functioning health care systems and distribution networks, amongst a wide range of other things.

The present understanding, however, is that human rights are considered "universal, indivisible and interdependent and interrelated" and states have obligations to respect, protect, and fulfil in relation to realizing all human rights.[34] The obligation to respect implies the above-described passive attitude of the state; states should refrain from interference in order to respect individuals' enjoyment of a right. The obligation to protect requires states to protect individuals against third-parties violating their human rights. The obligation to fulfil requires the state to take active steps towards facilitating in a system that enables individuals to enjoy their human rights, which they could not enjoy by personal efforts alone.[35]

For instance, the civil right to life implies that a state should not take an individual's life. To make sure it does not, it should respect the right to life by refraining from interference. However, states also have an obligation to protect individuals against violations of their right to life by third-parties, i.e. states should protect individuals against another person taking their life.[36] Furthermore, the social right to health implies obligations to fulfil by taking active steps so an individual can enjoy their right to health. To make sure they can, states should actively implement a national health plan and built hospitals, amongst other things. However, the state should also respect the right to health by refraining from polluting the air, which could cause harm to individual's health.[37] As a result, realisation of both types of rights implies obligations to respect, protect and fulfil, implying states should take active

---

32 M. Sepúlveda, *et al.*, *Human Rights Reference Handbook* (4th edition, Reykjavik: The Icelandic Human Rights Centre, University for Peace, 2009), at p. 3.

33 M. Scheinin, 'Characteristics of Human Rights Norms' in C. Krause and M. Scheinin (eds), *International Protection of Human Rights: A Textbook* (Turku Åbo: Institute for Human Rights Åbo Akademi University, 2009), pp. 19-37, at p. 22.

34 Vienna Declaration and Programme of Action (1993) A/CONF.157/23, at para. 5.; M. Scheinin, 'Characteristics of Human Rights Norms' in C. Krause and M. Scheinin (eds), *International Protection of Human Rights: A Textbook* (Turku Åbo: Institute for Human Rights Åbo Akademi University, 2009), pp. 19-37, at pp. 27-29.

35 M. Sepúlveda, *et al.*, *Human Rights Reference Handbook* (4th edition, Reykjavik: The Icelandic Human Rights Centre, University for Peace, 2009), at p. 17.

36 Art. 6 ICCPR.

37 CESCR, 'General Comment 14' *The Right to the Highest Attainable Standard of Health* (2000) E/C.12/2000/4.

steps towards realisation and refrain from interference.[38] Nonetheless, rights and obligations to ensure either CP rights or ESC rights are realised, are phrased differently in international legal instruments.

5.2 Realisation

In principle, CP rights should be realised immediately. This means that after ratifying a covenant a state is bound to effectively realise the rights included, to the full extent. As the realisation of ESC rights implies states to take active measures including the implementation of different systems and procedures, within their financial constraints, the Committee on Economic, Social, and Cultural Rights (CESCR), monitoring body of the ICESCR, acknowledged that realisation overnight would be unduly. Therefore, the CESCR outlined that the obligations as derived from the ICESCR are subjected to progressive realisation.[39] While the adoption of adequate measures includes a certain flexibility, the obligation to realise the rights enshrined in the ICESCR progressively is not one with an open end. Moreover, from the moment of ratification, states should take time-bound targeted and concrete steps towards full realisation.[40] In order to monitor compliance indicators and benchmarks should be established to measure the level of full realisation in a country.[41]

If all components of ESC rights would be realised progressively, however, the Covenant's *raison d'être* would be undermined. Therefore, in order to protect individuals' human dignity by ensuring at least the enjoyment of a basic standard of living, the CESCR outlined core obligations and obligations of comparable priority. These obligations are of immediate effect, which means that they, similar to CP rights, should be realised to the full extent immediately after ratification. States failing to comply with this core set of obligations, *prima facie* fail to discharge their obligations under the ICESCR satisfactorily.[42] The CESCR has appreciated the particular constraints of low-and middle income countries explicitly by imposing an obligation on high income countries to assist developing countries in realising socio-economic rights to the full extent, in accordance with the principle of international assistance.[43]

5.3 Prioritisation

Human rights are, in principle, non-hierarchical.[44] However, as their realisation depends to a large extent on available state resources, a certain level of prioritisation is necessary subject to justification. The level of prioritisation and the legitimacy thereof is determined by a rights status of being an absolute or relative right and by its progressive nature.

---

38 I.E. Koch, 'Dichotomies, Trichotomies or Waves of Duties?' (2006) 5 Human Rights Law Review 81, at p. 85; Maastricht Principles on Extraterritorial Obligations of States in the area of Economic, Social and Cultural Rights (2012). Available at: http://www.fian.org/fileadmin/media/publications/2012.02.29__Maastricht_Principles_on_Extraterritorial_Obligations.pdf [last accessed: 10 April 2013]; 'Maastricht Guidelines on Violations of Economic, Social and Cultural Rights' (1998) 20 Human Rights Quarterly 691, at para. 6.

39 CESCR, 'General Comment 3' *The Nature of State Parties Obligations* (1990) E/1991/23.

40 CESCR, 'General Comment 3' *The Nature of State Parties Obligations* (1990) E/1991/23, at para. 2. See also Constitutional Court Peru, *Azanca Alhelí Meza García*, 20 April 2004, Expte No. 2945-2003-AA/TC. Available at: http://www.escr-net.org/docs/i/405156. The Court reaffirms that the progressive nature of an obligation includes setting time-bound targets and benchmarks.

41 Center for Economic and Social Rights, *The OPERA Framework* (New York: Center for Economic and Social Rights, 2012), at pp. 6-8.

42 CESCR, 'General Comment 3' *The Nature of State Parties Obligations* (1990) E/1991/23, at para. 10.

43 Ibid, at para. 13.

44 Vienna Declaration and Programme of Action (1993) A/CONF.157/23, at para. 5.

The legitimacy of restricting a right depends on the status of a right as being absolute or relative. In principle, human rights cannot be limited and restricted as they are inalienable, which means that nobody can lose their human rights and human rights cannot be taken away from someone.[45] If prescribed by law, however, and found necessary in a democratic society, proportionate restrictions may be justified. In that case, a right qualifies as a relative right.

For instance, Article 22 of the International Covenant on Civil and Political Rights (ICCPR) enshrines the freedom of association stressing that: "everyone shall have the right to freedom of association, with others, including the rights to form and join trade unions for the protection of his interests."[46] As section two of the provision outlines, the right may not be limited except on the basis of those limitations as: "prescribed by law, and which are necessary in a democratic society in the interest of national security or public safety, public order, the protection of public health or morals or the protection of the rights and freedoms of others."[47]

However, if the law neglects to prescribe a justified limitation ground, limitations of a right are unlawful and a right classifies as an absolute right, i.e. no circumstance can justify a violation, and laws in conflict with these rights are void.[48] For instance, Article 7 of the ICCPR includes the absolute prohibition of torture: "no one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment."[49] By omission, the text of the treaty shows that no legitimate limitations apply.

Furthermore, the elements of ESC rights that are subjected to progressive realisation can be classified as relative rights. On the contrary, considering their immediate effect, core obligations and obligations of comparable priority can be classified as absolute rights as no situation can justify states failing to comply with these obligations. Moreover, as stated, states *prima facie* violate the ICESCR immediately if they fail to realise the set of core obligations and of obligations of comparable priority with respect to any one at any time.

Labelling rights and obligations as either absolute or relative is a tool to further qualify how one human rights norm relates to another, and has a guiding capacity in determining the scope and level of prioritisation between different rights or different elements of rights.

---

45 See Preamble and Art. 1 Universal Declaration of Human Rights (adopted 10 December 1948) UNGA Res 217 A (III) (UDHR); M. Scheinin, 'Characteristics of Human Rights Norms' in C. Krause and M. Scheinin (eds), *International Protection of Human Rights: A Textbook* (Turku Åbo: Institute for Human Rights Åbo Akademi University, 2009), pp. 19-37, at pp. 31-32.

46 Art. 22, section 1 ICCPR.

47 Art. 22, section 2 ICCPR.

48 See e.g. Art. 3 Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (adopted 10 December 1984, entered into force 26 June 1987) 1465 UNTS 85(CAT).

49 Art. 7 ICCPR.

6 Applying human rights to the two objectives of drug control

6.1 The right to health

The right to health is documented in many international and regional legal instruments, as well as included in different constitutional provisions.[50] For the purpose of this paper, however, its main scope and interpretation is analysed on the basis of Article 12 ICESCR and related documents, which reads as follows:

1. The States Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.
2. The steps to be taken by the States Parties to the present Covenant to achieve the full realization of this right shall include those necessary for:
    a. The provision for the reduction of the stillbirth-rate and of infant mortality and for the healthy development of the child;
    b. The improvement of all aspects of environmental and industrial hygiene;
    c. The prevention, treatment and control of epidemic, endemic, occupational and other diseases;
    d. The creation of conditions which would assure to all medical service and medical attention in the event of sickness.[51]

As the text of the treaty shows, the right to health includes the right to the highest attainable standard of health taking into account individual biological preconditions, socio-economic status, and states' available resources.[52] Although the implementation and application depends on country-specific conditions, the condition in which the right to health should be implemented is, in general, in accordance with the AAAQ-standard of health care: the right to health should be available, accessible, acceptable, and of good quality.[53] The right to health is considered an inclusive right, which means that it covers underlying determinants including safe drinking water and a clean environment, as preconditions to effective realisation of the right to health. In other words, in order to be healthy, or as healthy as possible, people not only need access to medicines but also to a clean and healthy environment.[54] At first sight, such an example seems to align the two objectives of drug-control defined with the right to health. However, in order to understand, how they relate to the different substantive elements of the right to health and in what qualification that correlation results, the right to health is

---

50 See e.g. Art. 25 UDHR; Art. 12 Convention on the Elimination of All Forms of Discrimination against Women (open for signature 1 March 1980, entered into force 3 September 1981) 1249 UNTS 13 (CEDAW); Art. 24 Convention of the Rights of the Child (adopted 20 November 1989, entered into force 2 September 1990) 1577 UNTS 3 (CRC); Art. 28 International Convention on the Protection of the Rights of All Migrant Workers and Members of their Families (adopted 18 December 1990, entered into force 1 July 2003) 2220 UNTS 3 (ICMW); Art. 25 Convention on the Rights of Persons with Disabilities (adopted 30 March 2007, entered into force 3 May 2008) 147 UNTS 99 (CRPD); Art. 16 African Charter on Human and Peoples' Rights (adopted 27 June 1981, entered into force 21 October 1986) 21 ILM 58 (ACHPR); Art. 3 European Social Charter (adopted 3 March 1996, entered into force 1 July 1999) (revised) CETS No. 163 (ESC); Art. 10 Additional Protocol to the American Convention on Human Rights in the Area of Economic, Social and Cultural Rights (adopted 17 November 1988, entered into force 16 November 1999) OAS, Treaty Series No. 69 (Protocol of San Salvador); Art. 22 Constitution of the Kingdom of the Netherlands, 1814; Art. 9 Constitution of the Republic of Chile, 1980.

51 Art. 12 ICESCR.

52 Art. 12, section 1 ICESCR; CESCR, 'General Comment 14' *The Right to the Highest Attainable Standard of Health* (2000) E/C.12/2000/4, at para. 9.

53 CESCR, 'General Comment 14' *The Right to the Highest Attainable Standard of Health* (2000) E/C.12/2000/4, at para. 12.

54 B.C.A. Toebes, *The Right to Health as a Human Right in International Law* (Antwerp: Intersentia, 2000), at pp. 254-259.

further elaborated on the basis of authoritative documents, in particular general comments 14 and 3 of the CESCR, complemented with relevant case law.

In general comment 14, the CESCR has outlined a list of substantive issues that arise at the level of implementing the right to health.[55] Five of these elements are singled-out. The selection is based on their correlation to one or both of the two drug-control objectives in their distinct ways, including the obligations to ensure the following: maternal health care services, including pre-and-post natal care; a healthy environment; the prevention, treatment and control of epidemic and endemic diseases; access to health facilities, goods, and services; and, access to essential medicines. The order of the elements singled-out follows the order of the general comment 14. Per substantive element, the status of the element is further elaborated and on the basis of different examples a correlation is traced with the access objective, the control objective, or both. The findings presented are summarised in Table 1 below.

Table 1: The application of the right to health to the two objectives of drug-control.

Human rights norm	**Substantive element**	**Status**	**(legal) Basis**	**Condition**	**Access objective**	**Right-holder**	**Control objective**	**Right-holder**
Right to health	Maternal care: - pre/post natal care	Absolute	Art. 12.2(a) ICESCR - CESCR GC 14 § 4/44(a)	AAAQ	**X**	Patients (mothers giving childbirth)	-	-
	Healthy environment	Relative	Art. 12.2(b) ICESCR - CESCR GC 14 § 15	AAAQ	-	-	**X**	Others if government fails to do so
	Prevention, treatment and control of epidemic and endemic diseases	Absolute	Art. 12.2(c) ICESCR - CESCR GC 14 § 16/44(c)	AAAQ	**X**	Pain patients Epilepsy patients IDUs	**X**	IDUs Others if governme nt fails to do so
	Access to health facilities, goods, and services	Absolute	Art. 12.2(d) ICESCR - CESCR GC 14 § 7/43(a)	AAAQ	**X**	Patients (incl. IDUs)	**X**	IDUs
	Access to essential medicines	Absolute	Art. 12.2(d) ICESCR - CESCR GC 14 § 43(d)	AAAQ	**X**	Patients (incl. IDUs)	-	-

6.1.1 Maternal health care services

Effective realisation of section 2, sub a, of Article 12 ICESCR imposes an obligation of comparable priority upon states to ensure maternal health and care by ensuring pre and post natal care are available to mothers giving birth, amongst other things.[56] The vital importance

55 CESCR, 'General Comment 14' *The Right to the Highest Attainable Standard of Health* (2000) E/C.12/2000/4.

56 Ibid, at paras. 14, 44.

of access to obstetric care is reaffirmed by The UN Committee on Elimination of Discrimination Against Women (CEDAW-Committee) in their decision in *Alyne da Silva Pimentel Teixeira (deceased) v. Brazil*.[57] One of the key interventions in decreasing the number of mothers dying in childbirth is the administration of ergometrine and oxytocin to stop post-partum bleeding.[58] These medicines, however, are widely unavailable as a result of being scheduled under the international drug-control treaties, amongst other things. The result being that at least 70,000 mothers die in childbirth.[59] Hence the access objective corresponds to adequate maternal health care services for the administration of obstetric care by ensuring access to ergometrine and oxytocin should be available. As being an obligation of comparable priority, however, the obligation to ensure the availability of ergometrine and oxytocin for obstetric care should be appreciated as an absolute obligation. The mothers who are denied access to the services described are the rights-holders to enforce states to comply with the obligation described.

6.1.2 Healthy environment

Effective realisation of section 2, sub b, of Article 12 ICESCR imposes the obligation of progressive realisation to adopt preventive measures to discourage "the abuse of alcohol, and the use of tobacco, drugs and other harmful substances."[60] As described, the main goal underlying the control objective is to protect individuals against the evil of drugs by prevention and control. Hence the objective directly correlates to states having an obligation to ensure a healthy environment under the right to health. As being an obligation of progressive realisation, however, the obligation should be appreciated as a relative obligation. At this point, no single rights-holder is identified, rather it could be claimed by anyone if a government fails to ensure a healthy environment and that individual is directly affected.

6.1.3 Prevention, treatment and control of epidemic and endemic diseases

Effective realisation of section 2, sub c, of Article 12 ICESCR imposes the obligation of comparable priority to ensure the prevention, treatment, and control of both epidemic and endemic diseases. In relation to the treatment and control of endemic diseases, states should create a system in which access to controlled medicines, including morphine and anti-epileptic drugs to ensure adequate pain and epilepsy treatment is available.[61] As pain is also a serious and common comorbidity of HIV/Aids, states should ensure access to pain treatment by means of (oral) morphine to ensure the treatment and control of epidemic diseases as well. Hence the access objective corresponds to the obligation of comparable priority to ensure adequate prevention, treatment and control of epidemic and endemic diseases, for a range of controlled medicines, but morphine in particular should be made available.

Furthermore, states should implement harm reduction programs including opioid substitute treatment and clean needle distribution programs, to prevent and control infectious diseases including HIV/Aids and Hepatitis B and C.[62] The control objective corresponds to the obligation of comparable priority to ensure prevention, treatment and control of epidemic diseases in particular, for harm reduction programs including substitute drugs which are scheduled under the international drug-control treaties, should be made available.

---

57 CEDAW-Committee, *Alyne da Silva Pimentel Teixeira (deceased) v. Brazil*, 6 August 2011, Communication No. 17/2008, at paras. 3.7-3.9.

58 WHO, *Medicines: Access to Controlled Medicines (Narcotic and Psychotropic)* (2010) Factsheet No. 336. Available at: http://www.who.int/mediacentre/factsheets/fs336/en/ [last accessed: 10 April 2013].

59 Ibid.

60 CESCR, 'General Comment 14' *The Right to the Highest Attainable Standard of Health* (2000) E/C.12/2000/4, at para. 15.

61 Ibid, at para. 16.

62 Ibid, at para. 16.

As being an obligation of comparable priority, all elements of this obligation, both in relation to the access objective and the control objective should be appreciated as an absolute obligation. All patients who are denied adequate access to medicines scheduled under the international drug-control treaties, and injection drug users (IDUs) in particular are identified as rights-holders.

6.1.4 Health facilities, goods, and services

Effective realisation of section 2, sub d, of Article 12 ICESCR imposes the core obligation to ensure "access to basic preventive, curative [and] rehabilitative health services", including "the provision of essential drugs."[63] As stated in the background section, controlled medicines are hardly available yet so badly needed in, and essential to, different medical interventions. Hence the access objective corresponds to the obligation to ensure access to health facilities, goods, and services, for a range of medicines scheduled under the international drug-control treaties are considered essential to different types of preventive and curative treatments.[64]

Furthermore, the obligation to ensure access to health facilities, goods, and services also includes the availability of rehabilitative services. Harm reduction programs are designed to reduce the harm of drug use to the individual user and society in general by focusing on behavioural modification.[65] Hence the control objective corresponds to the obligation to ensure access to health facilities, goods and services, for such harm reduction programs serve the purpose of preventing and controlling drug misuse. As being a core obligation, however, the obligation should be appreciated as an absolute obligation both in relation to the access objective and the control objective. The result being, all patients including pain patients, epilepsy patients, injection drug users, mothers in childbirth and those in need of acute care are identified as rights-holder.

6.1.5 Essential medicines

Effective realisation of section 2, sub d, of Article 12 ICESCR imposes the core obligation to ensure access to essential medicines as defined by the WHO in its essential medicines list.[66] The list includes a selection of medicines that are at the same time scheduled under the international drug-control treaties. As although its status of being a model or normative list remains debated, the classification of *essential* medicine already suggests that the list includes those medicines considered the most basic and essential to adequate care.[67] Hence the access objective corresponds to the core obligation to ensure access to essential medicines, including those scheduled under the international drug-control treaties. As being a

---

63 Ibid, at paras. 17 and 44.

64 See WHO, *Medicines: Access to Controlled Medicines (Narcotic and Psychotropic)* (2010) Factsheet No. 336. Available at: http://www.who.int/mediacentre/factsheets/fs336/en/ [accessed 10 April 2013]; WHO, *Access to Controlled Medications Programme* (2012) World Health Organization Briefing Note. Available at: http://www.who.int/medicines/areas/quality_safety/ACMP_BrNote_PainGLs_EN_Apr2012.pdf [last accessed: 9 April 2013].

65 See International Harm Reduction Association (Harm Reduction International), *What is Harm Reduction?* (2009) Position Statement. Available at: http://www.ihra.net/files/2010/05/31/IHRA_HRStatement.pdf [last accessed: 10 April 2013]; N. Ezard, 'Public Health, Human Rights and the Harm Reduction Paradigm: From Risk Reduction to Vulnerability Reduction' (2001) 12 International Journal of Drug Policy 207, at p. 207.

66 CESCR, 'General Comment 14' *The Right to the Highest Attainable Standard of Health* (2000) E/C.12/2000/4, at paras. 17, 43; WHO, *List of Essential Medicines* (2011). Available at: http://whqlibdoc.who.int/hq/2011/a95053_eng.pdf [last accessed: 10 April 2013].

67 WHO, *Essential Medicines* (2010) Factsheet No. 325. Available at: http://www.who.int/mediacentre/factsheets/fs325/en/index.html [last accessed: 10 April 2013].

core obligation, however, the access objective should be appreciated as an absolute norm under the right to health. All patients in need of those medicines listed as essential medicine and scheduled under the international drug-control treaties are identified as rights-holder.

6.2 The freedom from CIDT

The freedom from torture and CIDT is included in many international and regional legal instruments and constitutional provisions.[68] Torture is most comprehensively defined in Article 1 Convention Against Torture (CAT) as: "any act by which severe pain or suffering, whether physical or mental, is intentionally inflicted on a person" in order to get a confession or any other piece of information.[69] By omission, the CAT lacks a similar explicit reference of what defines an act of CIDT. In view of Article 16 CAT, however, acts of CIDT include:

> […] other acts of cruel, inhuman or degrading treatment or punishment which do not amount to torture as defined in article 1, when such acts are committed by or at the instigation or with the consent or acquiescence of a public official or other persons acting in an official capacity.

Both the freedom from torture and the freedom from CIDT are considered an absolute right, which means that violations of these rights are always unlawful.[70] In practice, the question whether or not an act is an act of torture or CIDT is a grey area, for acts of ill-treatment, the common reference of acts of CIDT, often facilitates acts of torture. Therefore, the Committee Against Torture (CAT-Committee), monitoring body to the CAT, stressed that the obligations explicitly imposed on states to protect individuals against acts of torture, apply by the same token to ill-treatment.[71] In any way, acts of torture or CIDT are considered a direct violation of a person's dignity and are considered one of the gravest violations of human rights.[72]

Traditionally, the scope of ill-treatment has not been directed towards the protection of public health explicitly. However, the Human Rights Committee (HRC), monitoring body to the ICCPR, has stressed explicitly in its general comment 20 that the scope and substantive elements of the prohibition of torture as included in the ICCPR includes the protection patients in medical institutions as well.[73] At present, discussions are taking place at the substantive law level placing access-to-treatment matters under the scope of the freedom from CIDT as well. Therefore, the two objectives of drug-control are related to the freedom from CIDT on the basis of recent developments supported by both present and former Special Rapporteurs (SR) of the United Nations on torture and CIDT. Notably, although stressed in the framework of analysis, the analysis seeks to find a basis for either the access objective, control objective or both in the present interpretation of the freedom from CIDT, rather than applying the right to the field of drug-control in general. The findings presented complemented with relevant case law and summarised in Table 2 below.

---

68 See e.g. Art. 5 UDHR; Art. 7 ICCPR; Art. 10 ICMW; Art. 15 CRPD; Art. 5 American Convention on Human Rights (open for signature 22 November 1969, entered into force 18 July 1978) 1144 UNTS 123 (ACHR); Art. 3 European Convention on Human Rights and Fundamental Freedoms (adopted 4 November 1950, entered into force 3 September 1953) CETS No. 005 (ECHR); Art. 5 ACHPR; Art. 12 Constitution of the Republic of South Africa, 1996; Art. 15 Constitution of Spain, 1978.

69 Art. 1 CAT.

70 See M. Nowak, 'Torture and Enforced Disappearance' in C. Krause and M. Scheinin (eds), *International Protection of Human Rights: A Textbook* (Turku Åbo: Institute for Human Rights Åbo Akademi University, 2009), pp. 151-182, at p. 153; Arts. 1 and 16 CAT.

71 CAT-Committee, 'General comment 2' *Implementation of Article 2 by State Parties* (20087) CAT/C/GC/2, at para. 3.

72 M. Nowak, 'Torture and Enforced Disappearance' in C. Krause and M. Scheinin (eds), *International Protection of Human Rights: A Textbook* (Turku Åbo: Institute for Human Rights Åbo Akademi University, 2009), pp. 151-182, at pp. 151, 182.

73 HRC, 'General comment 20' *Replaces General Comment 7 Concerning Prohibition of Torture and Cruel Treatment or Punishment (Art. 7)* (1992) A/47/40, at para. 5.

Table 2: The application of the freedom from CIDT to the two objectives of drug-control.

Human rights norm	Substantive element	Status	(legal) Basis	Condition	Access objective	Right-holder	Control objective	Right-holder
Freedom from CIDT	Access to pain treatment	Absolute	Art. 16 CAT/Art. 7 ICCPR Report SR - 2009 - 2013	-	**X**	Pain patients	-	-
	Access to opioid substitute treatment	Absolute	Art. 16 CAT/Art. 7 ICCPR Report SR - 2009 - 2013	-	**X**	IDUs	**X**	IDUs

6.2.1 Pain treatment

In different reports by Human Rights Watch, pain patients were given a voice expressing their wishes for the pain to be taken away and the desire to die rather than to live daily in such excruciating and unbearable pain.[74] According to these reports, their experiences resembled stories of torture survivors.[75] In its 2009 report, the Special Rapporteur on the issue of torture and CIDT, at that time Manfred Nowak, applied a human rights-based approach to drug policies and highlighted the hampering role of drug policies in access to palliative care and pain relief services.[76] Furthermore, in its 2013 report, current Special Rapporteur on torture and CIDT, Juan Méndez, lists specifically the denial of pain treatment as an emerging form of abuse in health-care settings.[77] Méndez outlines that: "denial of pain treatment involves acts of omission rather than commission, and results from neglect and poor Government policies, rather than from an intention to inflict suffering."[78] In other words, states failing to ensure adequate pain treatment is available by means of access to (oral) morphine are in breach of their obligations to protect individuals against ill-treatment. The European Court of Human Rights (ECtHR) supports this reasoning. In *Kupczak v. Poland* the Court maintains that the authorities had violated applicant's freedom from ill-treatment for they had denied applicant an implanted morphine pump implanted to control his pain.[79] Nevertheless, this does not mean that in each and every case a person suffers in pain it will result in an act of CIDT. Méndez outlines that the denial of pain treatment is only an act of CIDT: "when the suffering is severe and meets the minimum threshold under the prohibition against torture and ill-treatment; when the State is, or should be, aware of the suffering, including when no appropriate treatment was offered; and when the Government

74 Human Rights Watch, *"Please do not make us suffer anymore..." Access to Pain Treatment as a Human Right* (New York: Human Rights Watch, 2009), at p. 7.

75 Ibid; Human Rights Watch, *Unbearable Pain India's Obligation to Ensure Palliative Care* (New York: Human Rights Watch, 2009), at p. 19.

76 M. Nowak, *Report of the Special Rapporteur on Torture and other Cruel, Inhuman or Degrading Treatment or Punishment*, Human Rights Council 7th session (2009) A/HRC/10/44, at paras. 68-70.

77 J.E. Méndez, *Report of the Special Rapporteur on Torture and other Cruel, Inhuman or Degrading Treatment or Punishment, Human Rights Council, 22nd session* (2013) A/HRC/22/53, at paras. 51-53.

78 Ibid, at para. 54.

79 ECtHR, *Kupczak v. Poland*, 25 January 2011, Application No. 2627/09, at para. 68.

failed to take all reasonable steps to protect individuals' physical and mental integrity."[80] The result being, the access objective corresponds to the absolute obligation to protect individuals' freedom from CIDT. Moreover, the correlation to the access objective of drug-control is traced in the report itself. For Méndez supports that accessibility of medication, as defined by the WHO List of Essential Medicines, should be made available by states under the international drug-control treaties. By the same token as under the right to health, all patients in need of those medicines listed as essential medicine and scheduled under the international drug-control treaties are identified as rights-holder.

6.2.2 Opioid substitute treatment

Increasingly, arguments similar to the arguments supporting pain treatment as protected under the scope of the freedom from CIDT, are presented supporting the argument that denied access to opioid substitute treatment violates the freedom from CIDT of drug users as well.

Méndez stresses in his position as Special Rapporteur on the issue of torture and ill-treatment that the denial of opioid substitute treatment is "[a] particular form of ill-treatment and possibly torture of drug users."[81] What is more, the denial of methadone treatment is considered a breach of the freedom from CIDT in particular.[82] This is supported by the ECtHR in *McGlinchey and others v. The United Kingdom*. The Court held that the prison authorities had failed to protect applicant's freedom from ill-treatment because they failed to make adequate treatment including medications against heroin-withdrawal symptoms available.[83] Méndez extends this reasoning to apply to non-custodial settings as well. Thus states maintaining a complete ban on harm reduction programs including opioid substitute treatments are in breach of their obligations to protect the freedom from CIDT.[84] Hence both the access and control objectives correspond to the absolute obligation to protect individuals against ill-treatment, for in a contemporary understanding of the scope of that right, access to substances scheduled under the international drug-control treaties should be available for medical purposes, including harm reduction programs. In that light, drug users who are denied access to harm reduction programs including opioid substitute programs are identified as rights-holders.

---

80 J.E. Méndez, *Report of the Special Rapporteur on Torture and other Cruel, Inhuman or Degrading Treatment or Punishment, Human Rights Council, 22nd session* (2013) A/HRC/22/53, at para. 54.

81 Ibid, at para. 73.

82 Ibid.

83 ECtHR, *McGlinchey and others v. The United Kingdom*, 29 April 2003, Application No. 50390/99, at paras. 54, 57, 64.

84 J.E. Méndez, *Report of the Special Rapporteur on Torture and other Cruel, Inhuman or Degrading Treatment or Punishment, Human Rights Council, 22nd session* (2013) A/HRC/22/53, at para. 73.

7 Preliminary observations

In this phase of research, preliminary observations are presented, including an evaluation of both drug-control objectives qualified within the field of human rights law. The analysis outlined leads to three main observations.

Firstly, the analysis outlined suggests that the access objective, as singled-out in this paper, may be classified as an absolute human rights norm under the scope of the right to health. As the access objective is mainly directed towards ensuring access to adequate treatment by ensuring adequate medication is available, the objective can be translated to the obligation to ensure access to medicines, essential medicines in particular, under human rights law.

Secondly, the analysis outlined suggests that the control objective may be classified as both a relative and absolute human rights norm in two distinct ways. In the first way, the control objective may be classified as a relative obligation of progressive realisation by corresponding directly to the substantive element of ensuring a healthy environment under the right to health. In the second way, the control objective seems to imply the adoption of harm reduction programs including opioid substitute treatment. Although not mentioned explicitly, access to harm reduction programs is an absolute obligation, for it can be placed under the scope of different core obligations under the right to health and the freedom from CIDT.

Thirdly, taking into account the status and scope of the two objectives of drug-control in a human rights context, it seems that the balanced outset of drug-control would translate to a prioritised outset under human rights law. For the grassroots legal analysis presented enables a way in which the human rights qualification of the two norms can be evaluated in light of the absolute and relative nature of human rights obligations. In that light, the access objective seems to dominate over the control objective in a human rights context.

Obviously, these preliminary findings are subject to further research, and methods need to be finalised and applied to other human rights norms as well, in order to fully understand whether or not human rights law implies a priorities outset of drug-control instead of a balanced approach.

8 List of references

8.1 Legal instruments

8.1.1 International instruments

Universal Declaration of Human Rights (adopted 10 December 1948) UNGA Res 217 A (III) (UDHR).
Single Convention on Narcotic Drugs (adopted 30 March 1961, entered into force 13 December 1964) 520 UNTS 151 (Single Convention).
International Covenant on Economic, Social and Cultural Rights (adopted 16 December 1966, entered into force 3 January 1976) 993 UNTS 3 (ICESCR).
International Covenant on Civil and Political Rights (adopted 16 December 1966, entered into force 23 March 1976) 999 UNTS 171 (ICCPR).
Convention on Psychotropic Substances (adopted 21 February 1971, entered into force 16 August 1976) 1901 UNTS 175 (1971 Convention).
Convention on the Elimination of All Forms of Discrimination against Women (open for signature 1 March 1980, entered into force 3 September 1981) 1249 UNTS 13 (CEDAW).
Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (adopted 10 December 1984, entered into force 26 June 1987) 1465 UNTS 85 (CAT).
United Nations Convention Against the Illicit Traffic in Narcotic Drugs and Psychotropic Substances (adopted 20 December 1988, entered into force 11 November 1990) 1582 UNTS 95 (1988 Convention).
Convention on the Rights of the Child (adopted 20 November 1989, entered into force 2 September 1990) 1577 UNTS 3 (CRC).
International Convention on the Protection of the Rights of All Migrant Workers and Members of their Families (adopted 18 December 1990, entered into force 1 July 2003) 2220 UNTS 3 (ICMW).
Convention on the Rights of Persons with Disabilities (adopted 30 March 2007, entered into force 3 May 2008) 147 UNTS 99 (CRPD).

8.1.2 Regional Instruments

European Convention for the Protection of Human Rights and Fundamental Freedoms (adopted 4 November 1950, entered into force 3 September 1953) CETS No. 005 (ECHR).
American Convention on Human Rights (open for signature 22 November 1969, entered into force 18 July 1978) 1144 UNTS 123 (ACHR).
African Charter on Human and Peoples' Rights (adopted 27 June 1981, entered into force 21 October 1986) 21 ILM 58 (ACHPR).
Additional Protocol to the American Convention on Human Rights in the Area of Economic, Social and Cultural Rights (adopted 17 November 1988, entered into force 16 November 1999) OAS, Treaty Series No. 69 (Protocol of San Salvador).
European Social Charter (adopted 3 March 1996, entered into force 1 July 1999) (revised) CETS No. 163 (ESC).

8.1.3 Domestic Instruments

Constitution of the Republic of South Africa, 1996.
Constitution of the Republic of Chile, 1980.
Constitution of Spain, 1978.
Constitution of the Kingdom of the Netherlands, 1814.

8.2 Case Law and Individual Complaints

CEDAW-Committee, *Alyne da Silva Pimentel Teixeira (deceased) v. Brazil*, 6 August 2011, Communication No. 17/2008.
Constitutional Court Peru, *Azanca Alhelí Meza García*, 20 April 2004, Expte No. 2945-2003-AA/TC. Available at: http://www.escr-net.org/docs/i/405156
ECtHR, *Kupczak v. Poland*, 25 January 2011, Application No. 2627/09.
ECtHR, *McGlinchey and others v. The United Kingdom*, 29 April 2003, Application No. 50390/99.

8.3 Academic writing

Barrett, D., and Nowak, M., 'The United Nations and Drug Policy: Towards a Human Rights-Based Approach' in A. Constantinides and N. Zaikos (eds), *The Diversity of International Law* (Leiden: Martinus Nijhoff Publichers, 2009).
Boekhout van Solinge, T., *Dealing with Drugs in Europe: An Investigation of European Drug Control Experiences: France, the Netherlands and Sweden* (Ph.D. Dissertation, Utrecht: Willem Pompe Instituut voor Strafrechtswetenschappen, 2004).
Brennan, F., *et al.*, 'Pain Management: A Fundamental Human Right' (2007) 105 Anasthesia & Analgesia 205.
Cameron, A.,*Understanding Access to Medicines in Low- and Middle-Income Countries Through the Use of Price and Availability Indicators* (Enschede: Gilderprint Drukkerijen, 2013).
Ezard, N., 'Public Health, Human Rights and the Harm Reduction Paradigm: From Risk Reduction to Vulnerability Reduction' (2001) 12 International Journal of Drug Policy 207.
Gispen, M.E.C, *Poor Access to Pain Treatment: Advancing a Human Right to Pain Relief* (Utrecht: IFHHRO, 2012).
Koch, I.E., 'Dichotomies, Trichotomies or Waves of Duties?' (2006) 5 Human Rights Law Review 81.
Krause C., and Scheinin M., (eds), *International Protection of Human Rights: A Textbook* (Turku Åbo: Institute for Human Rights Åbo Akademi University, 2009).
Lohman, D., *et al.*, 'Access to Pain Treatment as a Human Right' (2010) 8 BMC Medicine 1;
Pettus, K.I., 'Rhetoric and the Road to Hell: The International Narcotics Control Regime and Access to Essential Medicines' (2012) 1 Bulletin Health Policy and Law 1.
Sepúlveda, M., *et al.*, *Human Rights Reference Handbook* (4th edition, Reykjavik: The Icelandic Human Rights Centre, University for Peace, 2009).
Seya, M.J., *et al*., 'A First Comparison Between the Consumption of and the Need for Opioid Analgesics at Country, Regional and Global Levels' (2011) 25 Journal of Pain & Palliative Care Pharmacotherapy 6.
Taylor, A.L., 'Addressing the Global Tragedy of Needless Pain: Rethinking the United Nations Single Convention on Narcotic Drugs' (2007) 35 The Journal of Law, Medicine & Ethics 556.
Toebes, B.C.A., *The Right to Health as a Human Right in International Law* (Antwerp: Intersentia, 2000).

8.4 Documents of international bodies

CAT-Committee, 'General comment 2' *Implementation of Article 2 by State Parties* (20087) CAT/C/GC/2.
CESCR, 'General Comment 14' *The Right to the Highest Attainable Standard of Health* (2000) E/C.12/2000/4.

CESCR, 'General Comment 3' *The Nature of State Parties Obligations* (1990) E/1991/23.
HRC, 'General Comment 32' *Article 14: Right to Equality Before Courts and Tribunals and to a Fair Trial* (2007) CCPR/C/GC/32.
HRC, 'General comment 20' *Replaces General Comment 7 Concerning Prohibition of Torture and Cruel Treatment or Punishment (Art. 7)* (1992) A/47/40.
INCB, *Report of the International Narcotics Control Board on the Availability of Internationally Controlled Drugs: Ensuring Adequate Access for Medical and Scientific Purposes* (2010) E/INCB/2010/1/Supp.1.
'Maastricht Guidelines on Violations of Economic, Social and Cultural Rights' (1998) 20 Human Rights Quarterly 691.
Maastricht Principles on Extraterritorial Obligations of States in the area of Economic, Social and Cultural Rights (2012). Available at: http://www.fian.org/fileadmin/media/publications/2012.02.29__Maastricht_Principles_on_Extraterritorial_Obligations.pdf
Méndez, J.M., *Report of the Special Rapporteur on Torture and other Cruel, Inhuman or Degrading Treatment or Punishment, Human Rights Council, 22nd session* (2013) A/HRC/22/53.
Nowak, N., *Report of the Special Rapporteur on Torture and other Cruel, Inhuman or Degrading Treatment or Punishment*, Human Rights Council 7th session (2009) A/HRC/10/44.
Vienna Declaration and Programme of Action (1993) A/CONF.157/23.
WHO, *Access to Controlled Medications Programme* (2012) World Health Organization Briefing Note. Available at: http://www.who.int/medicines/areas/quality_safety/ACMP_BrNote_PainGLs_EN_Apr2012.pdf
WHO, *Epilepsy* (2012) Factsheet No. 999. Available at: http://www.who.int/mediacentre/factsheets/fs999/en/
WHO, *Ensuring Balance in National Policies on Controlled Substances* (Geneva: WHO, 2011).
WHO, *List of Essential Medicines* (2011). Available at: http://whqlibdoc.who.int/hq/2011/a95053_eng.pdf
WHO, *Medicines: Access to Controlled Medicines (Narcotic and Psychotropic)* (2010) Factsheet No. 336.
Available at: http://www.who.int/mediacentre/factsheets/fs336/en/
WHO, *Essential Medicines* (2010) Factsheet No. 325. Available at: http://www.who.int/mediacentre/factsheets/fs325/en/index.html
WHO, *Cancer Pain Relief* (2nd edition, Geneva: WHO, 1996).
Yans, R., *Statement at the Fifth Session of the African Union Conference to Ministers for Drug Control* (2012). Available at: http://www.incb.org/documents/Speeches/Speeches2012/2012_October_CAMDC5_111012_eng.pdf

8.5 Other

Center for Economic and Social Rights, *The OPERA Framework* (New York: Center for Economic and Social Rights, 2012).
Count the Costs, *The War on Drugs: Undermining Human Rights*. Available at: http://www.countthecosts.org/sites/default/files/Human_rights_briefing.pdf
Global Commission on Drug Policy, ~~*War*~~ *on Drugs* (2011). Available at: http://www.globalcommissionondrugs.org/Report

Human Rights Watch, *"Please do not make us suffer anymore..." Access to Pain Treatment as a Human Right* (New York: Human Rights Watch, 2009).

Human Rights Watch, *Unbearable Pain India's Obligation to Ensure Palliative Care* (New York: Human Rights Watch, 2009).

International Harm Reduction Association (Harm Reduction International), *What is Harm Reduction?* (2009) Position Statement. Available at: http://www.ihra.net/files/2010/05/31/IHRA_HRStatement.pdf

International Harm Reduction Association (Harm Reduction International), *Global State of Harm Reduction 2008* (London: Harm Reduction International, 2008).

Jelsma, M., *The Development of International Drug Control: Lessons Learned and Strategic Challenges for the Future* (2011) Working Paper to the First Meeting of the Global Commission on Drug Policy. Available at: http://www.globalcommissionondrugs.org/wp-content/themes/gcdp_v1/pdf/Global_Com_Martin_Jelsma.pdf