Implementation of the UNGASS Outcome document

*Our joint commitment to effectively addressing and countering the world drug problem* with regard to human rights.

*Norway consider the UNGASS Outcome Document as the pivotal reference document in the field of drugs. It takes into account the broad and latest developments and emerging threats and thus represents the latest global consensus.*

Human rights are mentioned several times in the UNGASS outcome document as well as it contains a specific chapter regarding human rights. This reflects the increasing attention we have registered the resent years regarding drugs policies and human rights. From a Norwegian perspective this is very positive and it was also mentioned by Minister of Health and care Services, Mr. Bent Høie, at the UNGASs meeting as one of the positive achievements, though we still have a way to go.

Human rights have been present in the drugs debate in Norway for several years, also reflected in White Papers, Action Plans and legislative work. We do not claim that there is nothing in the outcome document to follow up and improve, but Norwegian drug policy is undoubtedly heading in the same direction. The latest development is that the Government has decided to reform the drug policy by providing healthcare as an alternative reaction to conviction and punishment. Among the main objectives by this shift is to remove stigmatisation of drug users and lower the threshold to contact and ask health professionals for help. This is however not necessarily directly resulting from having specifically assessed and intending to oblige to the human rights, nor the UNGASS document itself. It is rather like these topics and discussions goes in parallel and mutually affect each other in a positive manner.

In the *World Drug Report 2017*, UNODC observed that, globally, 28 million years of healthy life were lost in 2015 as a result of drug use. Of that number, 17 million years of healthy life were lost owing to drug use disorders, even though only around 10 per cent of the people who used drugs suffered from drug use disorders. Unfortunately, only one out of six people with drug use disorders globally have access to treatment services. It is a huge necessity to improve this at the international level, not only as a matter of capacity and access, but sadly to say, also as a result of attitude and political will.

Nationally, human rights aspect probably has had the longest and strongest impact exactly related to the right to health, described as “the right of everyone to the enjoyment of the highest attainable standard of physical and mental health”.

Treatment of drug use disorder does improve the physical and mental health of affected individuals, and is thus justifiably considered an element of the right to health. This is reflected in several acts aiming to remove the causes of ill-health and to ensure the right to access to health care like the Patients’ Rights Act of 2 July 1999 No. 36 (called the Patient’s and User’s Rights Act as of 1 January 2012), which contributes to securing equal access to good quality health care for patients. It is complemented by other legal Acts in the field of health care (Health Personnel Act, the Specialized Health Services Act, the Municipal Health and Care Services Act and the Mental Health Protection Act).

Since 2004, when the state took over the responsibility for the *Interdisciplinary specialised drug dependence treatment for substance use disorder* (Rusreform I and II), persons suffering from substance use disorder through the Patient And User Rights Act have the same patient rights as other patients in the specialist health services.

Related to treatment and rehabilitation services the conditions regarding availability, accessibility, acceptability and quality, the main challenge has been waiting time, but over the last years this has fallen significantly resulting from determined political emphasis, but we still have a way to go.

Through several White Papers, the Government has also initiated strategies aiming to reduce social inequalities in health, including actions in key areas, with more or less relevance on drug policy, such as:

* Children – ensuring that all children have equal opportunities regardless of their parents’ financial situation, education, ethnic identity and geographical identity.
* Working life – investments to promote a more inclusive labour market and steps to ensure a healthier working environment for all.
* Health services – investigation is taking place on the question of whether Norwegian health services are helping to level out health inequalities or if they are reinforcing them.
* Preventing social exclusion of marginalized groups, measures to promote inclusion in the workplace, inclusion at school and adapted health and social services.
* Strengthening considerations for health and distribution of health in all sectors – including a review and reporting system for monitoring progress, cross-sectoral tools such as health impact assessments and more systematic policy planning in the municipalities.

Persons who use drugs are often stigmatized and discriminated. To end this is not an easy task as it often is deeply rooted in the general population as part of everyday life. This impose a great challenge and responsibility on authorities at every level to counteract. Stigma is often expressed by negative loaded language. Thus it has been vital for the authorities to replace words like *drug abuser, combat/fight* by neutral and not stigmatizing language like *person who use drugs, address/counter* to mention some.

In the outcome document of the 2016 UNGASS on the world drug problem, UN member states reiterated a *“commitment to respecting, protecting and promoting all human rights, fundamental freedoms and the inherent dignity of all individuals and the rule of law in the development and implementation of drug policies”*. In drug policy—as in all other policy areas—human rights are not a choice, they are an obligation. Saying so is the easy part. But moving from commitments to policy and practice is no easy task. There is little existing agreement on what a ‘human rights-based approach’ to drug policy entails. The states’ commitment must be translated into practice.

Norway holds for the time being the presidency of the Council of Europe's Pompidou Group. The Group endeavours to support its member states in meeting their human rights obligations. To move beyond highlighting human rights problems Norway during its presidency has initiated a work to explore the application of human rights standards and tests as a basis for national and local led initiatives to incorporate human rights into drug policy development, monitoring and evaluation. This work has resulted in the report *Drug Policy and Human Rights in Europe: Managing tensions, maximising complementarities[[1]](#footnote-1),* worked out by Damon Barrett.

The death penalty is considered to be in contradiction with the principle of humanity and respect for the individual. Death penalty undermines human dignity and constitutes a violation of the prohibition of torture and cruel, inhuman and degrading treatment or punishment. Thus, Norway opposes all use of capital punishment in any context and would like to see a universal abolition. Norway considers it very worrying that the number of people being executed continues to increase, in spite of the fact that less countries practice the death penalty.

Clear restrictions set out in international law that where the death penalty yet is used, it can only be imposed for the “most serious crimes”. Despite this restrictions, several countries continue using the death penalty for drug-related offences. It is Norwegian position that drug-related offences do not qualify as "most serious crimes". We had hoped to have this reflected in the UNGASS outcome document, but unfortunately it was impossible to reach consensus on this position.

Our goal is the global abolition of the death penalty, and Norway works systematically at several levels towards this end. As a first step we seek a global moratorium. We urge countries that have not yet abolished the death penalty to introduce an immediate moratorium on the use of death penalty and to suspend all executions.

Norway had expected stronger language in the UNGASS outcome document also what harm reduction concerns as we consider as essential element regarding the right to health. Nationally we score high on the coverage of harm reduction measures and for the UNGASS follow up we will continue to a clear voice on this subject.

What Compulsory treatment, i.e. treatment administered without the expressed consent of the affected individual, concerns we refer to and take not as guiding principle the INCBs report (2017) stating that such treatment should be discouraged for the following reasons:

*(a)* The evidence for their effectiveness is poor;

*(b)* They threaten the health of people undergoing the treatment, including through increased vulnerability to HIV and other infections;

*(c)* They are in direct conflict with the human rights principles as stated in the International Covenant on Economic, Social and Cultural Rights.

Finally, we quote and affiliate the same INCB report stating that “Without due consideration of human rights, there are devastating consequences".

1. https://rm.coe.int/drug-policyandhumanrights-in-europe-eng/1680790e3d [↑](#footnote-ref-1)