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Submission to the UN Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health in response to call for submissions on racism and the right to health

Introduction

Open Society Foundations (OSF) make this submission in response to the Special Rapporteur's recent call for contributions to her forthcoming report on racism and the right to health. 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, especially to racialized communities. In this submission we argue that drug prohibition is inherently inconsistent with the right to health, anti-racist principles and anti-coloniality.

OSF's vantage point

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, transparency, accountability, and participation. An open society approach to tackling a public health and social challenge like use of potentially harmful substances would rely on evidence-based health and social interventions, 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, 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 minority populations, and to involve the unaccountable expenditure of huge amounts of public funds on mostly ineffective drug control measures. OSF's initial funding in this field roughly coincided with the height of the AIDS epidemic which, of course, 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 treatment-instead-of-incarceration initiatives in the United States; 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 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; efforts to help communities counter police violence and the deadly effects of militarized drug enforcement in the U.S., Latin America and the South East Asia; 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 support for the drug policy field and that of others 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 (see below for more detail), the institution of drug prohibition itself has undergone relatively little change. Millions of people continue to languish in jails and prisons solely

for using drugs or because they engaged in petty dealing or smuggling 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.

The racist and colonial roots of prohibition

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] Thus, the UN drug conventions frame drug prohibition as a global health intervention.

Notwithstanding this framing, 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 they 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 these countries 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.

[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 African Americans 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]

The racist and colonial legacy of prohibition today

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 in Brazil, 80% of those killed by police are Black or Indigenous and killings often occur during drug enforcement measures.[11] In countries like Australia and Canada, Indigenous populations

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[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.

are more likely to be arrested and imprisoned for drug offenses.[12] 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."[13]

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' presidents, evidence has repeated shown that the vast majority of victims are low wage earners residing in poor, urban neighborhoods.[14]
Colonial dynamics are also visible on the supply control side: 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.[15] Meanwhile, the former colonial powers that generate most of the demand for drugs have by and large avoided these corrosive impacts and their health consequences.

Less well-known but no less relevant, the processes the UN drug control treaties created to allow for continued use of allopathic medicines that contain controlled substances were designed to work for Global North countries with established medical supply processes and strong administrative systems. 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.[16] This is, in significant part, because the Global North

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[12] 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.
[13] OHCHR, 'Fight against world drug problem must address unjust impact on people of African descent, say UN experts,' 14 March, 2019.
[14] See, for example, Rodrigo Duterte's drug war pushed poor families deeper into penury, The Economist, June 2, 2022.
[15] 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)
[16] 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 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.

imposed drug control 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.

Best practices

The Special Rapporteur's call for contributions strongly emphasizes examples of best practice that address the impact of racist and colonial legacies in health. 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 best practices cannot be seen as a substitute for the more fundamental policy change that is urgently required: the end of drug prohibition itself. These best 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 minority and marginalized communities cannot be addressed effectively without a move away from a criminal justice 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.[17] OSF-grantees POS Foundation and the West Africa Drug Policy Network (WADPN) 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.

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[17] 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).

- **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 justice expenses to health and social services, including community-based interventions, for people who use drugs.[18]

- **New York, USA.** In 2021, New York signed into law the Marijuana Regulation and Tax Act (MRTA), establishing a new gold standard for an anti-racist end to marijuana prohibition.[19] The MRTA sets aside 50% of all commercial licenses for "social equity applicants," defined as individuals impacted by cannabis criminalization, Black people, minorities and others. In additional to preferential licensing, NY State has developed an "incubator fund" to support social equity applicants 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.

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.[20] The two sites, operated by a group called OnPoint, serve majority poor, Black and Latino

[18] 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

[19] 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).

[20] 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).

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 communities of color.

- **Services for crack users in Brazil.** OSF has supported a pioneering non-abstinence-based housing and employment program for homeless people who 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 homeless people 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.[21]

Recommendations

For far too long, the public health and human rights communities have quietly accepted the framing of prohibition as a necessary measure for countering health harms associated with drug use. Human rights institutions have tended to be agnostic on prohibitionist *per se* and have instead focused on denouncing human rights violations committed as part of its enforcement. Public health organizations, similarly, have tended to focus on the promotion of health interventions, like needle and syringe exchange, that address health needs of people who use drugs but do not challenge prohibition itself.

The cumulative work of the organizations we have supported over the last thirty years, however, leaves no doubt that the prohibition system is *inherently* inconsistent with the right to health and that the above-mentioned innovations can mitigate prohibition's health

[21] 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).

harms but not end it. The work of the organizations we have supported shows that prohibition is almost always associated with human rights violations such as overincarceration, stigma, discrimination, and racially biased and neocolonial application, thus undermining the right to health. Moreover, drug prohibition is not an effective institution for reducing health harms related to drug use as, in the words of the 2016 Lancet Commission on Public Health and International Drug Policy, the public health "harms of prohibition far outweigh the benefits."[22]

We thus urge you to use this report to move beyond the traditional approach that focuses on the abuses that result from drug prohibition—an approach that, in our view, ultimately legitimizes the continued reliance on drug prohibition—and to describe the institution itself as an oppressive structure in global health and as a human rights abuse.

Yours sincerely,

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[22] Csete J, Kamarulzaman A, Kazatchkine M et al., Public health and international drug policy, The Lancet, March 24, 2016. Available at: https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(16)00619-X/fulltext#seccestitle520 (accessed June 9, 2022).