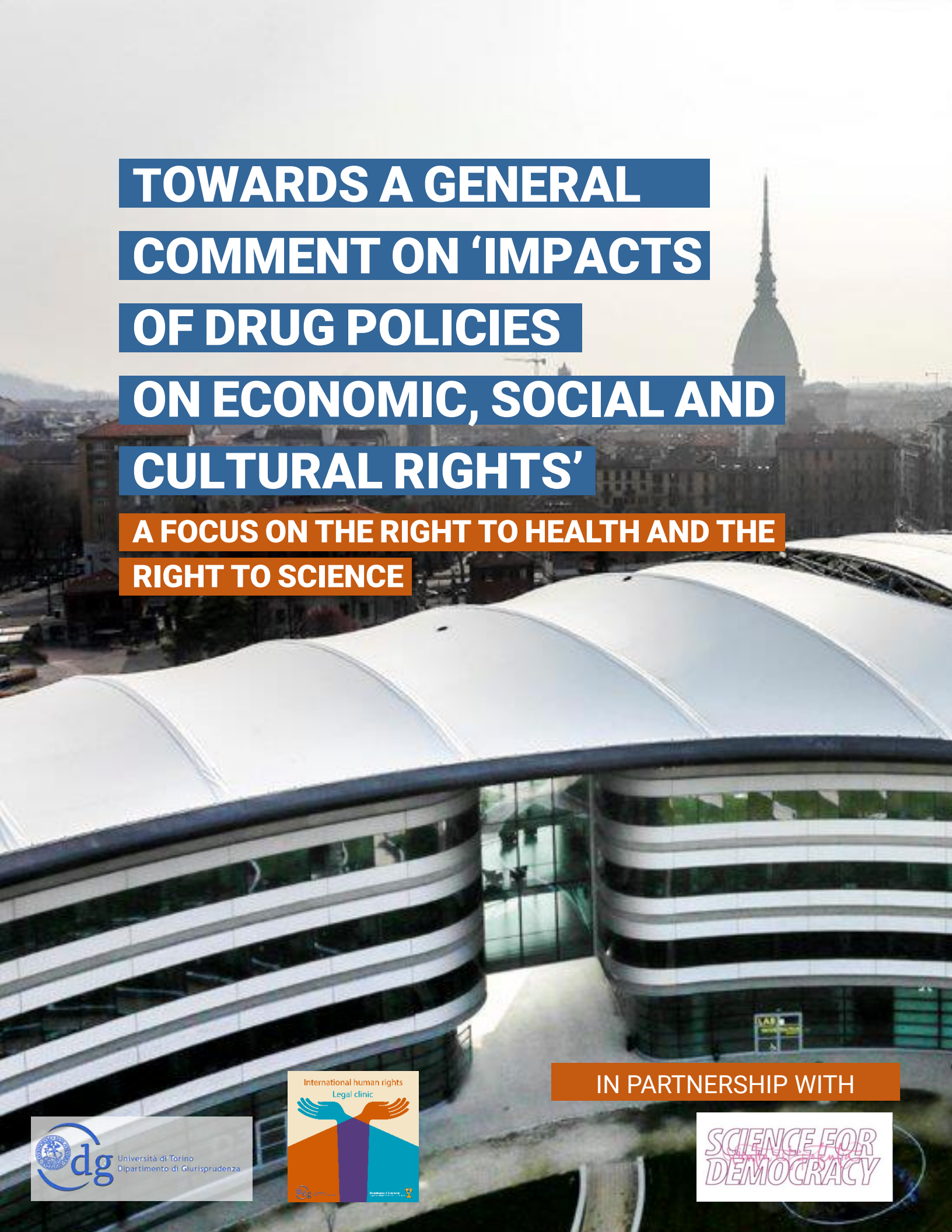
TOWARDS A GENERAL COMMENT ON 'IMPACTS OF DRUG POLICIES ON ECONOMIC, SOCIAL AND CULTURAL RIGHTS'

A FOCUS ON THE RIGHT TO HEALTH AND THE RIGHT TO SCIENCE



IN PARTNERSHIP WITH

Università di Torino
Dipartimento di Giurisprudenza

International human rights
Legal clinic

SCIENCE FOR DEMOCRACY

Contents

Executive Summary

Background

In its General Comment no. 25, the UN Committee on Economic, Social and Cultural Rights (UNCESCR) highlighted how the international drug control regime places unreasonable barriers upon and impairs scientific research of certain substances, classifying them as harmful to human health and without scientific or medical value, despite substantial evidence to the contrary. As a consequence, States' obligations under the regime do not always align with international human rights standards, thus making it necessary to harmonize the two frameworks. Against this backdrop, on 14 October 2022[1], the UNCESCR initiated a process towards the drafting and adoption of a new General Comment on 'Impacts of Drug Policies on Economic, Social and Cultural Rights'.

The Report, 'Towards a General Comment on Impacts of Drug Policies on Economic, Social and Cultural Rights: A Focus on the Right to Health and the Right to Science', aims to analyze the complex intersection between drug policies and economic, social, and cultural rights. The report builds upon CESCR General Comment No. 14 on the right to the highest attainable standard of health and General Comment No. 25 on science and economic, social, and cultural rights. Indeed, international human rights bodies, civil society organizations, and policymakers are increasingly focused on the impact of drug policies on the enjoyment of human rights, particularly the right to health, enshrined in Article 12 of the International Covenant on Economic, Social and Cultural Rights (ICESCR), and the right to science, enshrined in Article 15 of the ICESCR. Finally, the Report provides a detailed analysis of Italy as a case study.

A team of six students, all involved in the Strategic Litigation: International Human Rights Legal Clinic (University of Turin, Italy), conducted research and drafted the Report under

[1] See: https://www.ohchr.org/en/news/2022/10/committee-economic-social-and-cultural-rights-concludes-seventy-second-session-after

the supervision of Professor Andrea Spagnolo and Ms. Giulia Perrone, in partnership with Science for Democracy.

Students Involved

Claudia Paglia; Connor Maitland; Federica Iannó; Laura Pollio; Omayma Brahmi and Vanessa Lumci.

About our partners

Science for Democracy (SfD) promotes evidence-based debates and decisions, and advocates for the inclusion of the so-called "right to science" within the decision-making process at all levels. In particular, since its foundation in 2018, SfD has urged international law makers to ground the international drug control regime – including the disproportionate penalties often used to punish all the people involved in the production, consumption and trade of "controlled substances" – on recognised human rights standards, with particular attention to the right to health and the right to science. The activities of SfD include the organisation of science-related public meetings and the development of lobbying strategies, which involve representatives of governments and legislative assemblies, international organisations, UN agencies, civil society organisations and NGOs.

Content Overview

The report focuses on the impact of drug policies in the context of the right to science and the right to health. The analysis is conducted in light of the so-called *'AAAQ framework'* (Availability, Accessibility, Acceptability, and Quality) which sets out a behavioral threshold to be met by States in the implementation of both rights. The report is subdivided into four sections, namely: 1) the UN Drug Regime, 2) the Right to Health and the Right to Science, 3) Italy as a case study and 4) conclusions. The content of each section is briefly summarized below.

The UN Drug Regime

The UN drug control regime consists of three pivotal Conventions that aim to regulate the production, distribution, and consumption of drugs, primarily for medical and scientific purposes: the Single Convention on Narcotic Drugs (1961), the Convention on

Psychotropic Substances (1971), and the United Nations Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances (1988). The regime is criticized for its lack of scientific basis and its heavy reliance on political considerations and public morals. The UN Conventions adopt a strict prohibitionist stance due in part to the historical context in which they were drafted, beginning with concerns centering around opium abuse and illicit drug trafficking. Indeed, the inclusion of virtually all substances in the Schedules of the 1961 and 1971 UN Conventions on Narcotics creates unreasonable obstacles to scientific research and the benefits that may result from experimentation and clinical trials. Moreover, the Commission on Narcotic Drugs (CND), the International Narcotics Control Board (INCB), and the World Health Organization have raised critical concerns regarding the influence of political interests on the decision-making processes, particularly in the classification of drugs under the scheduling system. The regime's focus on punitive measures and criminalization results in 'unintended consequences', such as restrictions on access to lawful treatment for drug addiction and the perpetuation of illicit drug trafficking, which often clash with international human rights law and lead to tensions of norms on a global scale.

While the Conventions provide a minimum standard of enforcement, they also allow States parties to implement stricter measures, leaving room for subjective interpretations and potential breaches of human rights. As a consequence, the increased use of criminal sanctions and the general strictness of the drug control framework lead to conflicts between States' obligations to control narcotics and their obligations to promote and protect human rights.

I. The Right to Health and the Right to Science

The right to health and the right to science are enshrined, in Articles 12 and 15, respectively, of the International Covenant of Economic, Social, and Cultural Rights (ICESCR). The realization of each of the rights is closely interrelated with the other. Indeed, as pointed out by the CESCR in its General Comment No. 25: «Scientific progress creates medical applications that prevent diseases, such as vaccinations, or that enable them to be more effectively treated» thus «States parties have a duty make available and accessible to all persons, without discrimination, especially to the most vulnerable, all the best available applications of scientific progress necessary to enjoy the highest attainable standard of health».

II. Italy as a Case Study

Italy serves as a concrete example of the challenges and complexities that arise when norms relating to drug policies intersect with fundamental human rights. The initial de-criminalization of drug use in Italy led to harm-reducing public-health policies, but these measures were later viewed as condoning drug use and resulted in public moral opposition and a shift towards stricter criminalization. As a result, current drug policies in Italy, which reflect the international drug control regime, continue to hinder the full attainment of the rights to health and to science, leaving an overwhelmed criminal justice system with overcrowded jails and a lack of adequate assistance for addicted individuals. Indeed, the relevant legal framework falls short of providing accessible, acceptable, and quality in drug-related treatments and scientific research. Moreover, the lack of a national forum to discuss the efficiency of the legal framework in light of new scientific discoveries further impairs progress in drug policy reform.

Conclusions

This Report draws attention to the growing need to reform the international drug control regime in light of the evolving nature of medical and scientific knowledge, in order to properly align it with international human rights regimes. To this end, the Report encourages a stronger dialogue between the worlds of science and that of the law in the drafting of drug policies at the national and international levels. Additionally, throughout the Report, several recommendations have been made to the UNCESCR for the adoption of the General Comment on the 'Impacts of Drug Policies on Economic, Social and Cultural Rights.

Acknowledgements

The Legal Clinic is thankful for the insights and guidance provided by Science for Democracy.

The Legal Clinic is particularly grateful to Seree Nonthasoot, Member of the UN Committee on Economic, Social and Cultural Rights; Rapporteur for the General Comment on "Impacts of Drug Policies on Economic, Social and Cultural Rights "Towards a General Comment on "Impacts of Drug Policies on Economic, Social and Cultural Rights", Marco Perduca, Former Italian Senator (2008-2013), Co-Founder and Coordinator, Science for Democracy; and Rodrigo Uprimny, Professor at the National University of Colombia, researcher at the Center of Studies "Dejusticia"; former member of the UN Committee on Economic, Social and Cultural Rights for sharing their expertise with the students throughout the academic year. The Report does not necessarily reflect their own opinions.

The Legal Clinic thanks Jacqueline P. Padilla Torres, student tutor of the University of Turin, for her precious support with the graphics of the Report and the communication strategy.

Towards a General Comment on Impacts of Drug Policies on Economic, Social and Cultural Rights: A Focus on the Right to Health and the Right to Science

Introduction

The UN Committee on Economic, Social and Cultural Rights (CESCR) highlighted in its General Comment No. 25 the impairment of scientific research for certain substances due to international drug control conventions, which classify them as harmful to health without any scientific or medical value (§68). Despite substantial evidence supporting the medical uses of some of these substances, the international drug control system poses obstacles to conducting scientific research involving nearly all substances listed in the Schedules of the 1961 and 1971 UN Conventions on Narcotics. This creates unreasonable barriers to the potential benefits that could arise from experiments and clinical trials. Consequently, the obligations of States under this regime do not always align with international human rights standards, necessitating the harmonization of these two frameworks. In light of this situation, the CESCR has initiated a process to develop and adopt a new General Comment addressing the 'Impacts of Drug Policies on Economic, Social and Cultural Rights'.

This report will contribute to the development of the aforementioned General Comment, by demonstrating the implications of drug policies for the enjoyment of the right to health (art. 12 of the International Covenant on Economic, social, and cultural rights, ICESCR) and the right to science (art. 15 ICESCR).

The first section of this study provides an overview of the United Nations drug regimes, further exploring the UN bodies for drug control and presenting the issue of free

interpretation. The second section explores the codification of the right to science and right to health under the relevant international human rights instruments and their place within the UN drug regime. The third section addresses the impact of drug policies in Italy as a case study, by analyzing its historical development and assessing the compliance with the international obligations under the ICESCR.

Aims of the Report

The Report *Towards a General Comment on 'Impacts of Drug Policies on Economic, Social and Cultural Rights*': a focus on the right to health and the right to science', aims to demonstrate to the International Committee on Economic, Social and Cultural Rights how the lack of a scientific basis in the UN Drug Control regime affects drug policies and the consequent enjoyment of the right to science and the right to health.

To this end, the Report recommends an actual consideration of the most updated scientific studies for the drafting of the new General Comment on this merit, in accordance with the previous General Comments No. 14 and No. 25. In that light, the Report provides a case-study on Italy, the peculiarities of which may give useful insights.

The study was conducted by a group of six students, members of the Strategic Litigation Human Rights Legal Clinic of the University of Turin, supervised by Professor Andrea Spagnolo, Ms. Giulia Perrone and Mr. Mattia Colli Vignarelli, in partnership with Science for Democracy.

Section 1: The UN Drug Regimes

The United Nations narcotics regime is a set of international drug control treaties that regulates the production, distribution, and consumption of drugs across the globe. The three pivotal treaties are the Single Convention on Narcotic Drugs, 1961, the Convention on Psychotropic Substances, 1971, and the United Nations Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances, 1988.

These regimes date to the early 20th century after the British military engaged in a conflict in China that resulted in an advantage for drug smugglers, and concerns about opium abuse began to emerge. The first international treaty that aimed to regulate the production and distribution of drugs was the International Opium Convention, 1912. This instrument-imposed export restrictions but did not provide for the criminalization of either the substances themselves, their users, or producers of the raw materials used in the manufacturing of opium.

During World War I, agreements were suspended, and the newly established League of Nations incorporated the Convention and set up agencies to monitor its implementation.

Due to the limitations of the existing regulatory frameworks, the two most 'prohibitionist' countries at the time, the United States and China, withdrew from the negotiations that led to the International Opium Convention, 1925. The European colonial powers (France, Great Britain, Portugal, and the Netherlands) did not support the United States' approach, on account of the fact that they exercised a monopoly on drugs (opium, morphine, heroin, and cocaine) destined for the pharmaceutical market in Europe and the US.

After the Second World War, the United States, being the dominant political, economic, and military power, forged a new drug control regime, the Lake Success Protocol (1946) that laid the basis for the globalization of prohibitionist anti-drug ideals.

Subsequently, in the 1940s and 1950s, the United Nations held a series of conferences to address the issue of narcotic drugs, which resulted in the drafting of the Single Convention on Narcotic Drugs, 1961 (amended in 1971). The treaty aimed to establish a comprehensive system for prohibiting the production and distribution of narcotic drugs, including the control of raw materials, manufacturing, and distribution thereof, except in cases of

medical and scientific use and research. As a result, the Convention classified over one hundred substances in four different Schedules, based on dependence potential, abuse liability, and therapeutic usefulness. From the latter, it was deduced that the Single Convention took a more prohibitionist stance on plant-based drugs, such as cannabis, coca leaf, and opium, notwithstanding the poor and outdated scientific evidence.

In the 1960s, the drug market expanded with the emergence of psychoactive substances, a new category that comprised amphetamines and psychedelic drugs. Furthermore, the largest pharmaceutical companies located in Europe and in the United States pushed for the adoption of a more flexible regulatory framework than the one set by the Single Convention. These factors prompted a new wave of negotiations that culminated in 1971 with the adoption of the Convention on Psychotropic Substances, which extended the control over psychoactive drugs such as LSD and other hallucinogens. Overall, the convention introduced a less rigid mechanism of control and reporting with respect to the 1961 Convention, and it allowed the traditional use of some drugs in exceptional circumstances. For instance, the US government granted Native American tribes the right to continue to use peyote due to its use in indigenous customary practices. Moreover, more than 300 narcotics were scheduled in the Convention and 4 more Schedules were added according to their dependence potential and therapeutic value (Schedule I is the most restrictive, whereas substances in Schedule IV are recognized as having some therapeutic use). Similarly, to the Single Convention's scheduling system, the four Schedules only recognize drug use for medical and/or scientific purposes. Indeed, two out of the eight total Schedules prohibit the use of the listed narcotics even for medical use and allow limited quantities for scientific research purposes. However, this prohibition is merely arbitrary as it is not based on expert evaluation and research.

In the 1970s and 1980s, increased recreational demand for narcotics for non-medical purposes resulted in a significant growth in illicit production in those countries where the raw materials and plants were cultivated. Small criminal groups developed into large-scale narcotrafficking empires, which States tried to combat through the implementation of repressive measures abroad. US President Richard Nixon coined the term 'war on drugs' during a conference in 1971 where he declared narcotics to be 'public enemy number one'. As a result of US government policy, the United States became the leading country in the fight against narcotrafficking, particularly against Mexican cartels which were the main exporters of heroin and cocaine to the US domestic market. However, the support from the international community was lacking at the beginning. It is under these circumstances that the United Nations set up another conference to begin negotiations for the third and last convention on drug control, the Convention Against Illicit Traffic in

Narcotic Drugs and Psychotropic Substances, 1988. This regulatory framework set up a system of mutual legal assistance by imposing a duty on the ratifying States to adopt all necessary measures to combat illicit drug production, possession, and trafficking. The Convention also provides for two tables cataloging medical compounds and other substances that are commonly found in the illicit production of narcotic drugs and psychotropic substances.

It is important to mention that there is no express obligation under the treaties to criminalize drug use per se. As laid down in the Commentary to the 1988 Convention in Article 3, 'It will be noted that, as with the 1961 and 1971 Conventions, paragraph 2 does not require drug consumption as such to be established as a punishable offense'. Indeed, the treaties contain more repressive measures as regards the possession, distribution, and growing of plants for personal use. Moreover, contrary to public belief, narcotics under the 8 Schedules of the first two Conventions are not illegal per se, but they are subjected to different levels of control in order to ensure that their use is limited to the medical and scientific fields. The legitimization of this purpose is evident in all three Conventions. For instance, the 1971 treaty preamble, which refers to the Single Convention, states that it recognizes 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'.

The UN Bodies for Drug Control

Together, these treaties constitute the United Nations drug regime, which continues to provide the international framework for regulating the production and distribution of narcotics. In order to enforce the substantive provisions of these treaties, the Conventions have entrusted some pivotal enforcement responsibilities to three main UN bodies: the Commission on Narcotics Drugs (CND), the International Narcotics Control Board (INCB), and the World Health Organization (WHO). However, it is important to mention that the Conventions do not provide for a compliance mechanism.

The Commission on Narcotic Drugs is a legislative and decision-making body set up by the Economic and Social Council in 1946, which enforces the 1961 and 1971 conventions. Moreover, following WHO recommendations, it rules on the classification of narcotic drugs and psychotropic substances under the UN scheduling system. The influence of the CND on the international drugs scheduling system is perceived as potentially problematic, as the Commission is a de facto political body, and its considerations may be

based on national and international political interests rather than on scientific evidence and research.

The International Narcotics Control Board is an independent quasi-judicial organ established in 1968 following the Single Convention. It investigates the implementation of the treaties, and it issues reports. The INCB is also entrusted with assisting governments in the regulations of licit trade and drug production and in the improvement of controls over the illicit trafficking of narcotics.

Finally, the WHO Expert Committee on Drug Dependence is tasked with analyzing the medical properties of each narcotic and their impact on public health. The Committee carries out a detailed assessment of a substance, including its therapeutic value vis-à-vis the potential abuse thereof, and it consequently reviews the international classification under the treaties by recommending any necessary amendment to the CND. However, most of the substances under the Single Convention's Schedules, such as cannabis and cannabis resin, have not been assessed by experts for over 40 years and remain stringently scrutinized by the UN bodies and most States.

In light of these considerations, it may be argued that the UN drug control system is strongly prohibitionist in nature and that it is not solely based on scientific evidence. Instead, this system mostly operates on the basis of public consciousness, prejudice, and political considerations. Drugs and psychotropic substances are framed as a moral evil that the treaties aim to suppress a priori without resorting to science for the benefit of public health and welfare.

Consequently, the effectiveness and fairness of the UN drug regime is strongly contested and debated, especially as regards its impacts on human rights, such as the right to health and to science (Chapter II). Whereas this prohibitionist approach has found support in many countries, such as Italy and Ireland, many others have been trying to depart from the repressive framework in favor of a more humane drug control regime.

The issue of free interpretation and its 'unintended consequences'

The problem of free interpretation of certain international provisions is central to the scope of this work: in those areas where human rights risks exist, the interpretative approach can be extremely useful to reduce that risk. Varying interpretations and subsequent enforcement of the same provision may lead to a breach of international human rights law. This issue is intensified by the fact that the international drug control system became much stricter than before, leading to a more prohibitionist tone and placing more emphasis on single drug users. Consequently, this punitive approach together with the

quasi-universal ratification of the latest international drug control tools result in the increased use of penal sanctions within domestic legal systems as a method to eradicate the trade and consumption of drugs.

The criminal-focused nature of the most recent Conventions that establish and govern the drug control regime has resulted in different 'side-effects', which restrict the possibility for those addicted to narcotics to alleviate and treat their condition through lawful means. On the contrary, restrictive, and punitive policies trap addicts into a deleterious cycle of abuse, fostering the trafficking of drugs to the detriment of public health. Moreover, international human rights treaty law has been greatly developed and expanded over the past decades, making these two legal frameworks more likely to collide giving rise to tensions and conflicts of norms.

It is important to underline that the UN drug regime, besides the identification of the different categories of offenses, explicitly provides the obligation to sanction these offenses by establishing a 'minimum level of measures to be taken by all parties'. However, there is a permissive provision in each of the three drug conventions which allows States parties to take 'more strict or severe measures' than the ones listed in the treaties themselves, devolving to the Parties the implementation of criminal legislation without any human rights guidance. This framework of indirect control leaves room for the phenomenon of tensions of norms, which results in the breach of protected human rights that flow from States' individual, subjective interpretations, fulfillment, and enforcement of treaty obligations.

As Richard Lines clearly pointed out in his study *Drug and Human Rights in International Law (2017),* the current international narcotics control regime is characterized by three essential aspects, which make it likely to be the result of the so-called 'unintended consequences', giving rise to a conflict of norms between States contractual duties to control narcotics - in line with the ratified conventions - as well as their obligations to promote and further human rights internationally and domestically:

1. the near universal ratification of the core drug control instruments, which is the first and most important step to raise these norms to the rank of customary rules, being them characterized by both the consistent and general international practice by States, and by the subjective acceptance of the practice as law by the international community (*opinio juris*);

2. the parallel development of modern legal instruments and the increasingly comprehensive system of international human rights treaty law; and

3. the increased implementation of penal sanctions as a means to suppress the production, distribution, and use of narcotics;

Tensions of norms exist at the intersection of *ratione personae*, *ratione temporis*, and *ratione materiae*. That is, for a conflict to arise, the norms must implicate the same States with respect to the same subject matter and be simultaneously in force and valid. Regarding the international narcotic control regime and international human rights instruments, almost all States have ratified at minimum one of the above-mentioned international drugs treaties while at the same time ratifying international human rights instruments, such as the International Covenant on Economic Social and Cultural Rights, 1966. Therefore, the *ratione personae* condition is fulfilled. Similarly, these instruments are currently, simultaneously in force, therefore meeting the temporal condition, and it is incumbent upon signatory States to fulfill their obligations with respect to each field of law arising from the treaties. As for the subject matter concerned, it can be clearly demonstrated that, between the subjects at issue, significant tension arises from States' obligations to fulfill their narcotics control duties and the methods by which they do so.

For these reasons, a teleological approach, also described as 'dynamic' or 'evolutive', is the most appropriate to interpret the existing conventions. This approach, which finds its legal basis in Art. 31(1) of the Vienna Convention of the Law of Treaties (1969), seeks to interpret treaty provisions in a systematic way that gives rise to the full achievement of the aims and objectives of the treaties at issue. On the other hand, this interpretative approach can be a double-edged sword, depending on the values and domestic political realities of the ratifying States. As a result, States may enforce severe penalties, such as capital punishment or compulsory detention *en masse*. Even if the treaties' silence on the subject implies that the death penalty is a permissible sanction under international drug control law, as the Constitutional Court of Indonesia and the Government of India argue, the drug treaties clearly do not obligate or compel States to enact capital drug laws. In countries like these where internal wars are taking place, it would be less probable that narcotraffic could be punished with the same gravity as terrorism or other violations of international human rights law even though the Optional Protocol to the ICCPR reminds us that death penalty can be a solution for the most serious crimes. Indeed, the relevant human rights instruments hold that the aforementioned sanction constitutes a violation of the fundamental rights and freedoms of human beings. Therefore, a balanced approach should be adopted in the enforcement of the UN drug control treaties to restrict States' margin of discretion.

Article 49 of the 1961 Convention is a clear example of tensions of norms between the drug control regime and international human rights legal systems, as this provision

established a positive obligation on the part of ratifying States to suppress the chewing of coca leaves, a traditional practice of cultural significance to many indigenous peoples in South America's Andean region. In this regard, the adoption of an evolutive approach requires that the international legal protection of the cultural rights of indigenous coca-using communities should prevail over Article 49 of the 1961 Convention.

Another important issue in the field of interpretation is linked to harm reduction services. There is ample evidence and growing recognition in the sphere of international human rights law that access to harm reduction on a voluntary basis is a necessary component of the right to health under Article 12 of the International Covenant on Economic, Social, and Cultural Rights.

Finally, medical, and scientific knowledge is by its very nature constantly evolving and expanding. To this end, a clear and respectful human-centered approach is necessary to bind all States to guarantee equal protection of the right to health and the right to science.

Section 2: International Human Rights Framework: The Right to Health and the Right to Science

On 16 December 1966, the UN General Assembly adopted the International Covenant on Economic, Social, and Cultural Rights (ICESCR)[1]. As of 30 June 2023, 171 States have ratified the Covenant. The Covenant reflects the historical backdrop of the post-World War II era and the commitments adopted aim to enhance social progress and improve living standards. To that end, it reaffirmed the reliance on human rights and employed new international mechanisms.

In 1985, the United Nations Economics and Social Council established the Committee on Economic, Social and Cultural Rights (CESCR), a treaty body composed of 18 independent experts, in order to monitor the implementation of the ICESCR. One of the functions of the CESCR is to deliver *General Comments* that are authoritative interpretations of the ICESCR and which guide States Parties and other actors as to how to implement the rights enshrined in the Covenant.

Notably, General Comments clarify the meaning of the ICESCR and ensure that States Parties are continuously, consistently, and effectively implementing the Covenant. They also provide a framework for monitoring and assessing States Parties' compliance with their obligations under the Covenant. The CESCR delivers General Comments through a consultative process that involves inputs from States Parties, civil society organizations and other stakeholders. This process ensures that the General Comments reflect a broad range of perspectives and expertise.

The Right to Health and the Right to Science: International Human Rights Law

Drug policies have implications for the realization of a variety of human rights, including the right to health and the right to science.

The right to health and the right to science are strictly interrelated. The freedom to conduct scientific research and the right to enjoy the benefits of science and its applications have a direct link with the right to health which necessarily entails the obligation for States to ensure the conditions in which every person can be as healthy as possible. Indeed, scientific progress is crucial to the availability of medicines and vaccines, of health services, to healthy and safe working conditions, and to adequate housing and working conditions. Therefore, health is conceived not only as a human right but also an important aspect of scientific progress.
In order to guarantee the enjoyment of human rights law, the existence of an entity in charge of implementing these rights is necessary: first and foremost, this entity is the State, based on its ratification of human rights treaties. Moreover, some international treaties also provide for some entities in charge of monitoring the implementation by States of their obligations, creating a sort of double check system to guarantee the fulfillment of these rights. This is the case of the Committee on Economic, Social and Cultural Rights, the UN body which monitors the States' parties compliance with the ICESCR. The Committee produces an assessment of State compliance with the Convention, especially through the above mentioned General Comments which, although having a non-legally binding nature, represent an important authoritative and interpretative tool of the Covenant.

This section explores the normative content of these rights and the obligations placed on States parties to the ICESCR, read in connection with the UN drug regime.

The Right to Health

The preamble to the WHO Constitution, 1946, first recognized the right to health. It provides, 'The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social conditions'. Among the main sources of this right in international human rights law is Article 25 of the 1948 Universal Declaration of Human Rights (UDHR), which reads, 'Everyone has the right to a standard of living adequate for the health and well-being of himself and his family, including [...] medical care and the right to security in the event of [...] sickness, disability [...]'. The ICESCR recognizes 'the right of everyone to the enjoyment of the highest attainable standard of physical and mental health'. Additionally, the right to health is recognized in many regional human rights instruments, such as the European Social Charter of 1961, as amended in 1996. Even though the UDHR was adopted as a legally non-binding instrument, it was an influential authoritative source for the drafting of the ICESCR and the European Social Charter.

Despite the early establishment of the right to health, States and academic literature began to elaborate on the relationship between health and human rights only in the 1990s. At the start of this decade, attention was drawn to the fight against HIV/AIDS at the international level. The Office of the UN High Commissioner for Human Rights (OHCHR) International Guidelines on HIV/AIDS and Human Rights (1996) referred to the need for a 'human rights approach' to tackle the spread of HIV/AIDS and to ensure the protection of health as a human right. This approach called, for instance, the universal access to antiretroviral therapies.

The CESCR provided its authoritative interpretation of the right to health in two General Comments, namely, General Comment No. 14 on the right to the highest attainable standard of health (2000) and General Comment No. 22 on the right to sexual and reproductive health (2016).

In 2020, UN Member States, UN agencies and leading drug policy experts adopted the International Guidelines on Human Rights and Drug Policies, a set of human rights standards for States to support them in the development of drug policy frameworks in compliance with human rights. The Guidelines focus on four main non-binding obligations to respond to the harms caused by the prohibitionist and punitive approach of drug policies: harm reduction, drug dependence treatment, access to controlled substances as medicines, and the right to a safe and healthy environment. They also expand on the impact of drug policies on a wide range of rights, including civil and political rights, such as freedom from torture and cruel and inhumane treatment.

Drug policies significantly impact the right to health of specific groups of people, such as children, women, and indigenous people. The CESCR highlighted this interplay in the concluding observations of several country reports, in which it sets out recommendations for the State. For instance, in the concluding observations on the third periodic report of Kuwait (2021) concerning Article 12 ICESCR, it remarked that people in Kuwait with intellectual disabilities lack support to recover from addiction developed during the Covid-19 pandemic.

This impact is to be measured in conjunction with other international human rights instruments. In the case of children, the Convention on the Rights of the Child, 1989, and its Article 24 are fundamental to assessing the prevention, intervention, and protection of children in relation to drug abuse and the drug trade.

The Right to the Science

The right to science was recognized for the first time at the international level in Article XIII of the American Declaration on the Rights and Duties of Man, 1948, the first detailed human rights instrument that provides for the right to benefit from progress in science and technology.

The American Declaration heavily influenced the language used in the Universal Declaration of Human Rights (UDHR)) which was adopted almost seven months later. Article 27 it holds that: 'Everyone has the right freely to participate in the cultural life of the community, to enjoy the arts and to share in scientific advancement and its benefits'. Indeed, the Declaration was in part a response to the atrocities enabled by science and technology during WWII, as it called for a human rights-centered approach to avoid future international crimes. Additionally, in 1946, the United Nations Educational, Scientific and Cultural Organization (UNESCO) was established. This specialized UN agency lobbied for the inclusion of the right to science in the 1948 Universal Declaration.

The right to science was later included in the UN ICESCR, 1996, under Article 15, which expanded on Article 27 of the UDHR, 1948. However, this right is often overlooked by the States parties to the Covenant.

The right to science under the ICESCR is wide in scope and multifaceted. Indeed, it also includes, inter alia, the right to take part in cultural life (Art. 15(1)(a)), the freedom to conduct scientific and evidence-based research (Art. 15(3)), and the development and diffusion of science (Art. 15(2)). Whereas the UDHR states 'scientific advancement', the ICESCR focuses on 'scientific progress'. Despite the difference in wording, both refer to science as a predominant factor in the achievement of prosperity for humankind, as science is not only a matter of concern for professionals in the scientific and medical fields, but also for the common welfare of humankind. On the one hand, Article 15(1)(b) enshrines the right of all to enjoy the benefits of scientific progress and its applications. This article implicates the protection of indiscriminate access to scientific knowledge and evidence-based interventions, as well as the possibility to contribute to scientific efforts by, for instance, taking part in decision-making processes on the development and dissemination of science and technology. Indeed, doing science is not limited to scientists and professionals, but it is also extended to the concept of 'citizen science' which is carried out by ordinary people. For instance, plant research is a neglected field of study among big pharmaceutical companies and institutions, as it is not a lucrative business and plants are often unstable. The spread of 'citizen science' on plant research has positively impacted, inter alia, the use of therapeutic cannabis in countries such as Italy.

On the other hand, Article 15(3) protects, inter alia, the freedom to carry out scientific research independently and through autonomous research institutions. Indeed, scientific research on controlled drugs under the UN Drug Conventions' Schedules should be undertaken free from the obstruction of censorship and political interference. Additionally, international and national cooperation among the scientific community and the sharing of scientific data with policymakers and the public, when possible, are fundamental aspects of this right.

Unfortunately, the lack of a clear legal definition of the right to science has contributed to its ineffectiveness. Therefore, a new and more complete formulation was adopted by the CESCR in General Comment no. 25 on science and economic, social, and cultural rights: 'the right to participate in and to enjoy the benefits of Scientific Progress and its Applications'.

The Essential Elements of the right to health and the right to science: the AAAQ Framework

The right to health in all its forms and at all levels contains some interrelated and essential elements, the precise application of which will depend on the conditions prevailing in a particular State party. The Committee on Economic, Social, and Cultural Rights has set forth four essential elements of the right to health, namely the Availability, Accessibility, Acceptability, and Quality Framework:

a. *AVAILABILITY*: refers to the existence of services. Are goods and services sufficient in terms of quantity and type?

b. *ACCESSIBILITY*: it includes many components such as,

   I. physical accessibility;

   II. financial accessibility;

   III. bureaucratic/administrative accessibility;

   IV. social accessibility; and

   V. information accessibility

c. *ACCEPTABILITY*: are the services respectful of the culture of individuals, minorities, peoples, and communities? Are the services designed to respect relevant ethical and professional standards?

d. QUALITY: are facilities, goods and services based on the most advanced, up-to-date and verifiable science available at the time, according to the standards generally accepted by the scientific community?

Obligations of States Parties

General Legal Obligations

States parties are obligated to *respect*, *protect*, and *fulfill* to their maximum ability and within the context of the full use of their available resources the duties inherent to all provisions. In particular, they must pursue, achieve, and uphold the normative content of article 12 ICESCR, the right to health, and article 15 ICESCR, the right to science. While it is accepted that the achievement of these obligations may be realized in a progressive manner over a reasonable period of time according to States' resource limitations, it is undisputed that these obligations must be pursued as quickly as possible. Indeed, all undertaken measures must be clearly targeted to achieve the legal consequences of the provisions. To that end, States must be purposive in their pursuit of these aims to realize the material advancement of people's rights to health and to science.

The progressive advancement and achievement of the rights necessarily entail States' parties continuing duties to act effectively and urgently towards the full realization of the aims and objectives of Article 12 and Article 15 ICESCR.

Contracting States are obliged to fulfill all duties inherent to the rights contained in Articles 12 and 15 ICESCR, including the obligation to provide for the enjoyment of these rights without discrimination of any kind (Article 2(2) ICESCR) and the obligation to take immediate steps to progressively achieve full realization of these rights (Article 2(1) ICESCR).

The full realization of these rights is not merely an individual obligation. On the contrary, as the Committee highlighted in its General Comment no. 3, contracting States are equally obliged to assist and cooperate on an international level, specifically in the economic and technical spheres, to achieve the Covenant's objectives. This obligation is inherent to the spirit of Article 56 UN Charter and Articles 12 and 15 ICESCR. The full realization of the rights to health and to science are thus of universal common concern.

Core Obligations

Using the most immediate means possible in the context of the maximum use of their available resources, States must move to implement and achieve the Covenant's core priorities as quickly as possible.

'Nondiscrimination' is a central aspect when it comes to human rights law: States parties are obliged to eliminate all forms of discrimination in implementing the right to enjoy the benefits of scientific progress and the right to health.

Should a State fail to realize the core requirements of the rights, it is incumbent upon the contracting State to demonstrate it has acted to the full extent of its resource capacity and that every reasonable effort has been made to the achievement of the rights aims both individually and within the framework of international cooperation and assistance.

Specific Obligations

States parties undertake to *respect*, *protect*, and *fulfill* the Covenant's right to the maximum of their ability and resource capacity. Limitations of the full enjoyment of the rights may only be justified when determined by law in a democratic society and only insofar as any derogation is compatible with the nature of the rights and pursued solely for the purpose of promoting general welfare (Article 4 ICESCR).

Respect

States parties must *respect* the right to health and the right to science of all persons according to the principle of nondiscrimination. Contracting parties must furthermore ensure equal access to healthcare for detainees, ensuring the widest possible access to preventative, curative, and palliative care for all. With respect to the current report, States must provide users of drugs, whether incarcerated or not, the necessary treatments in order to combat addiction and drug use disorders. States must moreover identify, combat, and remove any discriminatory obstacles to healthcare and must at all times refrain from adopting measures that directly or indirectly impede the individual's access to the full enjoyment of the right to health.

State action must also be knowledge driven and, to the greatest possible extent, free of moral prejudice. States are obligated to refrain from taking regressive measures or those that interfere, whether directly or indirectly, with the full realization and enjoyment of the Covenant's rights. With respect to moral prejudice, States must aim to uphold and respect

traditional indigenous practices that use controlled substances and prevent dominant social mores from impeding indigenous people's right to practice traditional medicine and to benefit from traditional knowledge systems.

The promotion and dissemination of accurate scientific information such as to promote the education of the general population must be pursued. To this end, information about medical benefits and uses of drugs such as marijuana and others should be made freely available so that patients and medical practitioners can make informed decisions regarding healthcare treatments and choices.

Relatedly, the promotion of scientific education and research, the dissemination thereof, and elimination of all forms of obstacles and barriers thereto must be pursued. Drug trials, research, and enquiry must be supported and undertaken to ensure that greatest possible access to up-to-date scientific research and knowledge.

Finally, the promotion of and sincere cooperation in international efforts to promote scientific research, education, and access to scientific information must be achieved among States. The free-flowing exchange of the latest research results and information should be promoted to ensure equitable and fair access to information regardless of national boundaries.

Protect

Contracting States must *protect*, to the maximum availability of their resources, the right to health and the right to science.

With regard to the right to health, States must ensure equitable access to healthcare services, goods, and care and must guarantee that, where private healthcare services exist, this private nature does not impede the equal and equitable availability, access, and quality thereof for all. As regards healthcare practitioners and professionals, States must guarantee that these persons have been adequately educated to a scientifically appropriate standard and that they are endowed with the necessary skills to ensure sufficient care is provided to all. Moreover, the latest possible research and information must be made freely available to practitioners to ensure that the latest and most fulsome information is shared with patients regarding possible treatment plans. Furthermore, all practitioners and professionals must be bound to a high standard of ethics when administering care. States must also ensure that harmful cultural and religious practices and beliefs do not interfere with the individual's ability to receive appropriate healthcare as regards access to life-saving treatment, immunization against infectious diseases, and reproductive and family planning. At all times, adequate and appropriate measures must be taken to

guarantee that marginalized and minority groups, including women, girls, gender and sexual minorities, and the elderly are able to access appropriate healthcare, services, and goods, such as necessary medication. At no time may a third party or entity interfere in the delivery of healthcare or related services and goods to any person or group.

Similarly, States are obligated to adopt measures, whether in the form of administrative, judicial, or legislative acts, budgetary policies, and/or other government programs and public policies that *protect* the right to science. Equally, contracting parties are obliged to refrain from adopting measures and taking decisions that undermine those rights. Furthermore, States must prevent any third parties from obstructing the objectives and guarantees defined in the Covenant whether internally or externally.

Non-exhaustive examples of the duty to protect the right to science include ensuring that public and non-State institutions such as schools, universities, laboratories, hospitals, scientific and cultural institutions, associations, and other bodies guarantee the right to participate in and enjoy the benefits of scientific knowledge, progress, and the application thereof on a nondiscriminatory basis. Furthermore, any such institution or body must adhere to established, transparent, and accepted ethical codes and standards when conducting research. These institutions and bodies must also follow strict ethical standards when conducting, disseminating, and promoting scientific research, always refraining from the dissemination of disinformation or misleading data.

In addition, special protection must be afforded to marginalized communities and groups, in particular, minors or those who otherwise lack full capacity to consent. At all times, the best interests of the child must be of paramount importance.

Fulfill

States have a legal obligation to ensure that all necessary measures and acts are adopted in such a way as to ensure the full enjoyment of the right to health. At its core, the obligation to *fulfill* requires States to provide healthcare services in an equitable manner, including full access to appropriate preventative, curative, and palliative care. The nature of the provision of healthcare services may be public, private, or mixed, but at all times must be affordable and equitably accessible.

Healthcare facilities must be equitably distributed throughout the territory of the States parties, be sufficient in number, and provide access to healthcare services and goods, including mental health treatment, addiction counseling and treatment, and sexual healthcare, including for the treatment of sexually transmitted infections (STI), in particular HIV/AIDS. Where access, infrastructure, or other means to achieve full health equality

is lacking, States are obligated to undertake additional obligations and responsibilities to ensure equitable access to healthcare for all. States must likewise ensure that appropriate and adequate education services are available to individuals as regards STIs, mental health, and addiction counseling and services, including the treatment of drug addiction, tobacco, and alcohol use. Access to research results and education must be promoted and made freely available.

States are also under information duties as regards scientific progress and its applications, including in the field of healthcare; in particular, States must promote research and education in the healthcare field, ensure that healthcare practitioners and professionals are appropriately and adequately trained to confront specific needs of marginalized and minority groups, including as regards cultural nuances and differences in approach to health, and States must counter the dissemination of harmful, false, and misleading information while always ensuring that access to accurate and appropriate information is available freely and equitably such that individuals and patients may make freely informed and consenting opinions as regards their health and bodily autonomy.

States parties must facilitate, provide for, and promote the complete attainment and enjoyment of the right to science and full, fair, and equal access to the benefits of scientific knowledge, progress, and applications thereof. This necessarily includes the duty to adopt any and all necessary and sufficient administrative, legislative, judicial, and budgetary measures required to fully achieve the right to science. Where obstacles or barriers to the full enjoyment of the right exist, States are obliged to provide effective remedies to those concerned. At all times, States must be proactive in identifying and dismantling obstacles to the full enjoyment of the right.

To guarantee the fulfillment and enjoyment of the right to science, States must adopt measures that grant the widest possible access to scientific education and knowledge, which includes the active identification and combating of disinformation and misleading information and the active challenging of harmful moral and social stigmas that undermine the full enjoyment of the right. Ensuring free and open access to the Internet and other sources of scientific knowledge necessarily flows from this duty. Additionally, States must not only ensure the full participation of individuals in the enjoyment of science but must equally promote and fund education and research in scientific fields and medical research.

Section 3: Italy as a case study

Italy provides a compelling case study for the legislative and penal approaches to drug policy and drug criminalization and their implications for the full realization and enjoyment to the rights to health and to science. Italy's policy approaches to drug prohibition, control, and penalization have been influenced by popular referendums on the subject, changes in government that characterize the Italian political landscape, as well as external influences, such as the 2006 Olympic Winter Games.

In 1990, the Italian government introduced and enacted a strict drug penalization law, Law n. 309/90, that carried harsh criminal sanctions for those found in possession of drugs and for users of prohibited substances. In line with the national Constitution, over 500.000 signatories were collected in 1993 to force a referendum on the matter. By a simple majority of over 53%, Italian voters voted to remove criminal sanctions from the Law at issue, and for a brief time that followed, drug use in Italy was decriminalized.

What followed was a period characterized by harm-reducing public health policies. In particular, Turin, located in the Northwest of the country, undertook a harm-reduction policy approach with vigor. Safe injection sites were introduced, methadone was provided to users of heroin, and appropriate after-injection care was made available to users of drugs. While these measures successfully mitigated the harmful impacts of addiction and drug use, society grew increasingly wary of them. Rather than seeing the policies for the harm-reducing acts they were, large swaths of Italian society came to view these measures as condoning an indiscriminate use of drugs. Consequently, a strong moral opposition arose to the provision of safe injection sites, the provision of methadone, and after-injection care to users of drugs.

In 2006, in the lead-up to the Winter Olympics and during the final weeks of Silvio Berlusconi's second government, the government issued a new decree (the so-called Fini and Giovanardi Law) that prohibited, criminalized, and placed penal sanctions on the possession and use of drugs. While this measure was ostensibly justified on grounds of attempting to prevent doping during the Olympic Games, the measure was silent on this topic and was aimed at the common citizen. It laid the groundwork for subsequent legislative measures that have had deleterious effects on Italian society.

Subsequently, in 2007, the Italian government enacted the 'three strikes rule' whereby prison was mandated for persons who had had three encounters with the law concerning drug offenses. This caused an explosion in the Italian prison population; a system designed to house 40 000 persons exploded to over 90 000 incarcerated persons.

In later years, civil society groups challenged the validity and legality of these measures. In 2014, the Constitutional Court invalidated the 2006 amendment to the 1990 law. In response, the central left government of the day adopted a new decree that, in effect, aimed to decriminalize personal possession of cannabis for personal use. However, this has not resulted in wide decriminalization, and to date, there exist over a quarter of a million ongoing criminal proceedings in Italy for drug violations.

The foregoing thus sets out the erratic, confused, and contradictory nature of Italian drug policy and law.

The impact of the current drug policies in Italy on the right to science and the right to health

There are several documented instances in which the current legal regime hinders the full realization of the rights to health and to science, in all their configurations, enshrined in the Declarations and Treaties mentioned in the previous sections of this report.

This position is endorsed by a plethora of organizations that have joined the "Support. Don't Punish" initiative, "a global grassroots-centered initiative in support of harm-reducing drug policies that prioritize public health and human rights" as part of their efforts to advocate for a fairer, better-informed approach to the regulation of drugs.

The Law n. 309/90 ('Testo Unico sugli stupefacenti e sostanze psicotrope') is the main governing Act for drug-related issues in Italy. Despite having undergone multiple modifications throughout the years, to this day, it falls short of providing an effective framework to address the multifaceted, far-reaching challenges posed by the matters it seeks to regulate.

The effects of this law are detailed, on a yearly basis, in the so-called *Libro Bianco sulle Droghe* (i.e., 'the White Book on Drugs', hereinafter 'Libro Bianco'), an independent report drawn up and sponsored by a number of associations, which zeroes in on the consequences on the criminal justice system, the healthcare sector, as well as the way and the extent to which services are offered and enjoyed by the general public.

The 2022 edition, the 13th edition overall, devoted considerable attention to the proposal for a referendum to amend law No. 309/90 in articles 73(1), 73(4), and 75(2) that was presented, in early 2022, to the Italian Constitutional Court, which ultimately declared it inadmissible.

The articles mentioned above detail the scope of application of pecuniary, criminal and administrative sanctions for whoever imports, acquires or possesses illicit substances for personal use.

As already underlined in previous editions of the Libro Bianco, one of the most critical consequences of the Law n. 303/90 is the tremendous impact on the criminal justice system, both in terms of congestion of the judicial apparatus and of overcrowding of jails, which, although beyond the scope and aim of this report, is worth mentioning.

Due to the current rigidity of the Law, the staggering number of people who are involved in criminal proceedings due to drug-related charges flowing from articles 73 and 74 has put great strain on the criminal justice system, which is simply overwhelmed by the number of individuals and cases to process.

Penitentiary facilities are starkly overpopulated, which has already been a ground for reproach to the Italian Government by the European Court of Human Rights, according to which, as stated in the 2013 Torreggiani judgment, the Italian government is in breach of article 3 of the European Convention on Human Rights.

Of special concern is that the Libro Bianco insists that the convictions flowing from the misapplication and overuse of art. 73 D.P.R 303/90 fuel such a tremendous situation.

Circling back to the subject matter and scope of the present report, one of the lesser-mentioned impacts of the current Italian drug policy regime is that many of those convicted for drug-related crimes are also addicted users of drugs and, as long as they are imprisoned, they are also prevented from receiving the assistance they need and deserve.

Clearly, if the addiction is not promptly treated and addressed in due course, the addict will likely struggle again, upon their release.

Not only is this vicious cycle of incarceration ineffective, it also reinforces the claims that these policies are not focused on harm reduction at all and that the current legal regime is inadequate, inefficient, and downright harmful insofar as it precludes the full enjoyment of the right to health.

This line of argument has already sparked intense debate, with the opposers of harm-reduction policies arguing that the latter are equivalent to the State condoning a conduct that is forbidden by the law.

Another example that further evidentiates the inadequacy of these provisions is the peculiar position of Italian pharmacies: any general medical practitioner in Italy is legally allowed to prescribe derivatives of cannabis for medical use, after having explored all other 'traditional' options to no avail.

However, although the sale of cannabis derivatives for medical use is lawful as well, pharmacies cannot advertise. Doing so could lead to stark administrative sanctions, as has already happened, on the grounds that, since cannabis is a prohibited substance, per Article 84 Law n. 309/90, it should not be promoted or otherwise advertised to the general public.

This questionable situation gives rise to several other complications, especially considering that offering a service that cannot be publicized fuels the already-problematic lack of accessibility to these substances for medical purposes.

As argued in the previous section, the situation is hardly aided by Italy's frequent change of political direction.

There is still insufficient awareness and unconscionable prejudice on the topic, among laypeople and the ruling class alike, and that is reflected in our legal regime, which is long overdue for an upgrade, possibly one that is grounded on an up-to-date scientific foundation.

Explanation of the AAAQ normative framework applied to the right to science and the right to health for the drafting of drug policies.

This section assesses the compliance of the Italian drug policy regime with its international obligation under the ICESCR for the enjoyment of the right to health and the right to science in light of the AAAQ framework.

Availability

Drug-related treatment is managed at regional level by local healthcare authorities which are funded by the Department of Anti-Drug Policies. This type of treatment is provided for by both public and private facilities and through two main complementary systems which

are the Ser.Ds (public drug dependency service units) and residential or semi-residential therapeutic structures. The former are part of the national health system and offer outpatient treatment, whereas the latter are mainly provided by non-governmental organizations and provide inpatient and outpatient treatments. Interventions by the Italian healthcare system include psychosocial support and detoxification, but also harm-reduction services such as needle and syringe programmes (NSPs) and information disclosure. The harm-reduction approach was introduced in 1999 and became an essential part of the levels of healthcare (LEA) by virtue of a decree of the President of the Council of Ministers in 2017. However, the local implementation of these services still lacks homogeneity and uniformity. The Ser.Ds are a key player in the delivery of these treatments. Indeed, interventions such as opioid substitution treatments (OST) are provided only within the Ser.Ds system since they require a multisectoral and professional approach. However, drug-related treatments are mostly standardized and do not consider the individual experiences of the patients. Additionally, Law 94/98 (Law di Bella) enables doctors to choose to treat their patient with an 'off-label' drug, namely a therapy with a different therapeutic indication or alternative mode of administration that does not comply with the official authorizations of the AIFA (Italian Drug Agency) and the Ministry of Health. This is allowed as long as the choice is based on updated scientific evidence and literature and is supported by favorable data as outlined in the Law 296 of 27 December 2006 or 'Legge Finanziaria 2007'. The prescription of off-label drugs implies both an increase in the unpredictability of the risks to the health of the patient and a problem of an ethical nature as clinical practice is influenced. These factors strongly weigh on the responsibility of lawmakers to innovate a sector on which strong scientific evidence is lacking.

In Italy, scientific research on the impact of drug policies is managed by the Department for Anti-Drug Policies (DAP) in collaboration with other institutions such as the National Health Institute and the National Statistical Office, as well as universities and other local organizations. Indeed, the universities of Modena and Reggio Emilia have recently discovered new active components of cannabis.

Accessibility

Italy was one of the first countries in Europe to adopt a law that allows the prescription of cannabis for medical use. This happened in 2006 and, since then, Italy has been importing cannabis and other products from The Netherlands in accordance with an agreement concluded with the Dutch Ministry of Health. However, as mentioned in the previous section, it cannot be promoted or advertised to the general public. Additionally, due to the increase in demand, in 2015 the plant was grown for medical and scientific purposes by

a pharmaceutical institute in Florence run by the Italian military and recognized by the WHO, the INCB, and AIFA. The distribution of the cannabis by the establishment is carried out through tenders. However, access to the research on the quality and properties of these plants is restricted. Moreover, scientific research on drug use in Italy is strongly discouraged by, inter alia, the length of bureaucracy in issuing permits for the growth or acquisition of plants for scientific and medical purposes, the mystification and manipulation of raw data, and the scarcity of funds.

As regards accessibility to drug-related treatments, by virtue of policies such as the 2017 decree, harm-reduction services are guaranteed to all Italian citizens. Although the majority of these services are provided solely in the northern regions, there are programs targeting specific categories of people, including children and adolescents who use drugs, ethnic minorities, and incarcerated people. As regards the latter, strategies have been outlined to ensure that these people can access the same level of healthcare services and drug-related treatments as the general public.

Acceptability

In Italy, the legislation on drugs has not prompted meaningful changes for over 30 years. It is still largely based on Law 309/90 which promotes the punitive approach of the so-called "war on drugs" and criminalizes not only the substances but also the people who use them. This is apparent when comparing the numbers of drug addicts sentenced to prison since the entry into force of the Law. In 1990 they amounted to 7,299, whereas, in December 2020, 18,757 people were detained for violating the law on drugs. The ECtHR in the Torreggiani sentence, as detailed above, uncovered this shocking reality when the ECtHR found that prison overcrowding in Italy has become a structural phenomenon that goes beyond the mere case at hand.

Additionally, the department tasked with the strategic management and coordination of drug policies at a national level is specifically worded as Department on "Anti-Drug" Policies, thereby showing its stance on drug regulation. Indeed, the word "drug" in Italian does not have a dual meaning as in English in which it describes both the narcotic and the medicine. On the contrary, it stands for the narcotic alone and is, therefore, embedded with negative connotations arising from centuries of political and social prejudice.

Quality

In light of international and national obligations, including the Italian National Action Plan on Drugs (2010-2013), Italy should undertake annual quality assessments and

evaluations of drug policies and other interventions at the country level based on scientific data and procedures. Nevertheless, the Department on Anti-Drug Policies has not complied with these duties. Moreover, a national conference should be held every 3 years to discuss the efficiency of the law in light of new scientific discoveries. The last conference dates back to 2009 in Trieste, but it was widely considered as irrelevant and inconsequential for the long-overdue reform of the drug policy framework. As a result, civil society organizations had proposed to arrange a national conference that should have taken place in Milan in February 2020, but due to the pandemic, it was suspended.

On the other hand, local authorities at the regional level have been trying to outline and plan uniform interventions by creating guidelines for, inter alia, the evaluation of the quality of drug-related treatments and scientific research on the implications of drugs in their territories. Some regions have also invested in training courses targeted to psychologists on substance use. However, budget cuts to public health in recent years and the Covid-19 pandemic have posed a significant obstacle to these endeavors.

The reform of drug policies in Italy is a bottom-up process in the hands of some local administrations, encouraged by advocacy efforts of civil society associations. The desire for change is apparent, but it remains clouded by years of political manipulation and stigma.

Italy as a case study: Final remarks

In conclusion, there are multiple factors which may contribute to the phenomenon of tensions of norms and Italy serves as a concrete example of the challenges and complexities that arise when norms related to drug policies intersect with fundamental human rights.

Following the analysis carried out above it is evident how social, economic, and political rights all play a role within the definition of certain policies, especially when it comes to such a sensitive topic like drugs prohibition and criminalization. Considering the Italian case, the continuous change of governments, together with a lack of scientific data and the influence of external social events resulted in a lack of coherence within the policy-making outcomes, thus within the legislation. They tend to shift from being too permissive or rather excessively stringent, incapable in any case of reaching that balance needed to avoid the compliance with a framework of norms (the international drug control system) at the expense of another (fundamental rights). In particular, the analysis shows how these policies may impede access to scientific research on drugs, limit the availability of evidence-based treatments, and hinder the enjoyment of the right to health and the right to science of individuals addicted to drugs.

Furthermore, the aforementioned policies show a clear inability to take into account scientific data for their definition, an aspect which, instead, should constitute the starting point for the policymaking procedure on this topic. The dialogue between the world of science and that of the law, besides being often inflated by the role of the media or overshadowed by the importance of economic or social events, truly constitutes one of the key to comply with the international drug control regime without affecting the protection of certain human rights, particularly the right to health and the right to science.

In conclusion, Italy has made efforts to align its drug policies with human rights principles, but there are still challenges to overcome. It is crucial for policymakers in Italy, and other countries facing similar issues, to ensure that drug policies are in line with human rights standards, including the AAAQ normative framework, to promote the well-being and dignity of individuals who use drugs while upholding their fundamental rights.

Concluding observations

The UN drug control regime, consisting of the three pivotal international drug control treaties, has been criticized for its lack of scientific basis and heavy reliance on political considerations and public consciousness. Indeed, the regime takes a strict prohibitionist stance, due to its roots in an historical context where concerns about opium abuse and drug smuggling emerged. Nevertheless, the first aim of the abovementioned treaties is to regulate the production, distribution, and consumption of drugs, primarily for medical and scientific purposes.
Critical concerns regarding the influence of political interests on the decision-making processes, particularly in the classification of drugs under the scheduling system, have been raised by three main monitoring bodies, meaning the Commission on Narcotic Drugs (CND), The International Narcotics Control Board (INCB) and the World Health Organization. The regime's deep focus on punitive measures and criminalization has resulted in 'unintended consequences', such as restrictions on access to lawful treatment for drug addiction and the perpetuation of illicit drug trafficking, which often clash with international human rights law and lead to tensions of norms on a global scale.
In fact, the treaties provide a minimum level of measures to be taken by the signatory States, but they also allow states to implement stricter measures, leaving room for subjective interpretations and potential breaches of human rights. It is precisely the increased use of penal sanctions and the general strictness of the regime envisaged, which led to conflicts between states' obligations to control narcotics and their obligations to promote and protect human rights.
Against this background, it is crucial to balance the enforcement of the drug control treaties with respect for human rights, taking into account the evolving nature of medical and scientific knowledge and highlighting the growing need for a more evidence-based approach to drug control.

The report also focuses on the importance of the International Covenant on Economic, Social, and Cultural Rights (ICESCR) and its role in promoting social progress and improving living standards. The Committee on Economic, Social and Cultural Rights, in delivering authoritative interpretations of the ICESCR provisions through its General Comments,

play a crucial role in highlighting the importance of an explicit reference to the right to science, along with the right to health, in the drug control regime.

Taking Italy as a case study, where popular referendums, political turmoil, and external factors (like the 2006 Olympic Games) deeply influenced the definition of drug policies, serves as a clear example of the erratic and contradictory approach to drug prohibition, control, and penalization. The initial decriminalization of drug use in Italy led to harm-reduction and public health policies, but these measures were later viewed as condoning drug use, leading to moral opposition and a shift towards stricter criminalization. As a result, the current drug policies in Italy hinder the full realization of the rights to health and science, leaving a criminal justice system overwhelmed, overcrowded jails, and lack of adequate assistance for addicted individuals. Indeed, the law falls short in providing accessibility, acceptability, and quality in drug-related treatments and scientific research. Moreover, the lack of a national forum to discuss the efficiency of the law in light of new scientific discoveries further hinders the progress in drug policy reform.

Throughout the present report, several recommendations were made, such as the shift to an evidence-based approach in the drafting of future drug policies. States must likewise respect indigenous people's traditional medicinal practices that entail the use of controlled substances; in particular, States must aim to balance dominant domestic social mores, their obligations under the UN treaties, and respect for traditional knowledge systems and practices.

In light of the above, it is evident the growing need of reform of the international drug control regime, in order to properly align it with the international human rights regime, avoiding legal tensions and the impediment of the progress on the protection of human rights at the international level.

Bibliography

Aust, A. Vienna convention on the law of treaties (1969). *Max Planck Encyclopedia of Public International Law*. (2006). Oxford Public International Law: Vienna Convention on the Law of Treaties (1969) (ouplaw.com)

Council of Europe, *European Social Charter*, 18 October 1961, ETS 35, available at: https://www.refworld.org/docid/3ae6b3784.html

Council of Europe, *European Convention for the Protection of Human Rights and Fundamental Freedoms, as amended by Protocols Nos. 11 and 14*, 4 November 1950, ETS 5, available at: https://www.refworld.org/docid/3ae6b3b04.html

Decreto del Presidente Della Repubblica 9 ottobre 1990, n. 309 'Testo unico delle leggi in materia di disciplina degli stupefacenti e sostanze psicotrope, prevenzione, cura e riabilitazione dei relativi stati di tossicodipendenza.' (GU Serie Generale n.255 del 31-10-1990 - Suppl. Ordinario n. 67). Gazzetta Ufficiale

Dettaglio. (n.d.). https://www.federfarma.it/Mobile/Home/Agi/dettaglio.aspx?id=94083

ECHR. (n.d.). HUDOC - European Court of Human Rights. https://hudoc.echr.coe.int/fre#{%22itemid%22:[%22001-115937%22]

EMCDDA, Italy Country Drug Policy Report 2019, 6 June 2019, European Monitoring Centre for Drugs and Drug Addiction, available at Italy, Country Drug Report 2019 | www.emcdda.europa.eu

Global Commission on Drug Policy. (2019). Classification of psychoactive substances: When science was left behind. Gazzetta Ufficiale. (1990, October 31). https://www.gazzettaufficiale.it/eli/id/1990/10/31/090G0363/sg

Hunt, Paul. *Interpreting the International Right to Health in a Human Rights-Based Approach to Health*, 2016, *Health and human rights* vol. 18,2 (2016): 109-130.

Informati! - Referendum per la cannabis legale. (2022, February 14). Referendum per La Cannabis Legale. https://referendumcannabis.it/informati/

Inter-American Commission on Human Rights (IACHR), *American Declaration of the Rights and Duties of Man*, 2 May 1948, available at: https://www.refworld.org/docid/3ae6b3710.html

Inter-Agency, *International Guidelines on HIV/AIDS and Human Rights*, July 2006, HR/PUB/06/9, available at: https://www.refworld.org/docid/4694a4a92.html

Jelsma, M, Armenta, A. (2015). The UN Drug Control Conventions: a Primer. Report prepared for the Transnational Institute (TNI, 2015), primer_UNconventions_20102015-EC.indd (tni.org)

Legge 8 aprile 1998, n. 94 'Conversione in legge, con modificazioni, del decreto-legge 17 febbraio 1998, n. 23, recante disposizioni urgenti in materia di sperimentazioni cliniche in campo oncologico e altre misure in materia sanitaria'. (Published in the G.U. 14 April 1998, n. 86), available at LEGGE 8 aprile 1998, n. 94 - Normattiva

Lines, R. (2018). *Drug Control and Human Rights in international law,* Cambridge University Press, 2018. Drug Control and Human Rights in International Law (cambridge.org)

Perduca, M. (2023). Guest Lecture for Strategic Litigation: International Human Rights legal clinic. *"The impact of Drug Policies on the Enjoyment of Human Rights in Italy"*. University of Turin. 2023, February 21.

Romano, Cesare P.R. (April 27, 2020). *The Origins of the Right to Science: the American Declaration on the Rights and Duties of Man*. The Right to Science: Then and Now, Cambridge University Press, Porsdam H. and S. Porsdam Mann (eds.) (forthcoming 2021), Loyola Law School, Los Angeles Legal Studies Research Paper No. 2020-12, Available at SSRN: https://ssrn.com/abstract=3587133

Sagone, P. (2022). Droghe. Il tredicesimo Libro Bianco sugli effetti della legislazione antidroga sul sistema penitenziario e giudiziario italiano. AliAutonomie. https://aliautonomie.it/2022/07/01/droghe-il-tredicesimo-libro-bianco-sugli-effetti-della-legislazione-anti-droga-sul-sistema-penitenziario-e-giudiziario-italiano/

Support. Don't Punish. (2023, March 31). The campaign - Support. Don't Punish. Support. Don't Punish. https://supportdontpunish.org/about/campaign/

The Right to Science, Then. (2021). In H. Porsdam & S. Porsdam Mann (Eds.), *The Right to Science: Then and Now* (pp. 15-104). Cambridge: Cambridge University Press. The Right to Science, Then (Part I) - The Right to Science (cambridge.org)

UN Committee on Economic, Social and Cultural Rights (CESCR), *General Comment No. 14: The Right to the Highest Attainable Standard of Health (Art. 12 of the Covenant)*, 11 August 2000, E/C.12/2000/4, available at: https://www.refworld.org/docid/4538838d0.html

UN Committee on Economic, Social and Cultural Rights (CESCR), *General Comment No. 25: on science and economic, social and cultural rights (article 15 (1) (b), (2), (3) and (4) of the International Covenant on Economic, Social and Cultural Rights), 30 April 2020, E/C.12/GC/25, available at: E/C.12/GC/25 (un.org)*

UN Committee on Economic, Social and Cultural Rights (CESCR), *Concluding observations on the third periodic report of Kuwait, paras. 33-34, 3 November 2021,* E/C.12/KWT/CO/3, *available at:G2131488.pdf (un.org)*

UN General Assembly, *Convention on the Rights of the Child*, 20 November 1989, United Nations, Treaty Series, vol. 1577, p. 3, available at: https://www.refworld.org/docid/3ae6b38f0.html

UN General Assembly, *International Covenant on Economic, Social and Cultural Rights*, 16 December 1966, United Nations, Treaty Series, vol. 993, available at: https://www.refworld.org/docid/3ae6b36c0.html

UN General Assembly, *Universal Declaration of Human Rights*, 10 December 1948, 217 A (III), available at: https://www.refworld.org/docid/3ae6b3712c.html

UN General Assembly, *Entry into force of the constitution of the World Health Organization*, 17 November 1947, A/RES/131, available at: https://www.refworld.org/docid/3b00f09554.html

Verdier, P.H., Versteeg, M. (2015). International Law in National Legal Systems: An Empirical Investigation. *The American Journal of International Law*, *109*(3), 514–533. (2015). https://doi.org/10.5305/amerjintelaw.109.3.0514